VS A15 (4) 15M 10/57

23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COM

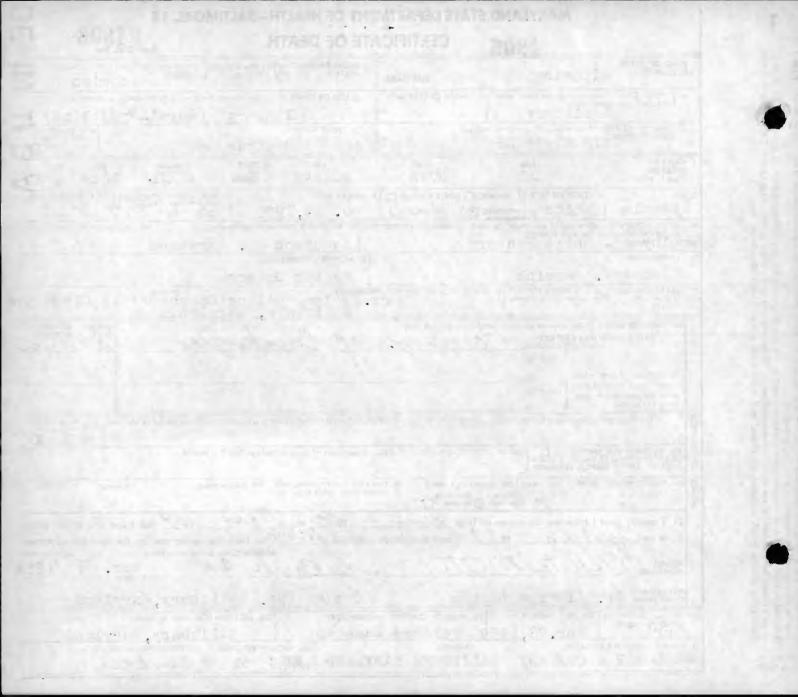
	4905	CERTIFIC	ATE OF DEATI	1		() 4 () Reg. Dist.	396 No.	
1. PLACE OF DEATH o. COUNTY	Wicomico	MARYLAND	2. USUAL RESIDENCE (WI	land	ed. If institution b. COUNTY	W1CO		ision)
b. CITY OR TOWN RURAL and give	(If outside corporate limits, write negrest town) Salisbury	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (IF	_	4			
d. NAME OF HOSP OR INSTITUTION			d. STREET ADDRESS	Sbury Clyde		1_Fru	e. IS RE	SIDENCE A FARM?
3. NAME OF DECEASED (Type or print)	HAZEL.	Middle RUTH	BOZMAN	4. DATE OF DEATH	APR]		Doy 6th	Year
5. sex Female	6. COLOR OR RACE 7. MAR WIDOW	RIED NEVER MARRIED DE DIVORCED	B. DATE OF BIRTH Feb. 19,19		AGE (In years ast birthday) 56 yrs.	Magins Da	EAR IF UND	
Employee	ON (Give kind of work done 100 orking life, even if retired) Shirt Facto		Somerset	Co. Ma			S A	(COUN
James	W. Warwick		Beulah D					
	/ER IN U. S. ARMED FORCES? 16.	SOCIAL SECURITY NO. 17.	INFORMANT S. Evelyn Wa Salisbur	llage(Daught	ër)ll	8 Cly	rde
PART I. DE	ony, which [b] [b]	lor (o), (b), and (c).]	a of Eso	plage	ia		NTERVAL BI	DEATH
PART II. O	(c) (c) (THER SIGNIFICANT CONDITIONS	CONTRIBUTING TO DEATH BL	UT NOT RELATED TO THE TERM	INAL DISEASE CO	PNDITION GIV	EN IN PART 1(c	19. WAS PERFO YES	DRMED?
	AS UNDERLYING 20b. DES G CAUSE OF DEATH Y MEDICAL EXAMINER)	CRIBE HOW INJURY OCCUR	RED. (Enter nature of injury in	Part I or Part II a	of item 18.)			
20c. TIME OF INJU Hour o. m. p. m.	While	Not while 1	PLACE OF INJURY (Home, form octory, street, office bldg., etc.	20f. (City or t	'own)	(Cour	(עיוו	(Stot
ACTUAL SIGNATURE	that I attended the decease and 26. 19. Clerta 77. Or. Alberta Ma	and that deal	, 19 <u>5.2</u> , ta th accurred at 7:00 M.D. 7// <i>Carm</i> Camden Av	Den an	city or town,	Apr	date state	
220. BURIAL, CREMATI- REMOVAL (Specific BUTIAL)	vì l	22c. NAME OF CEMETERY	OR CREMATORY	22d. LOCATION	City, town, o	r county)	(Sto	,
23. FUNERAL DIRECTO		ADDRESS	Cemetery	Sa.	1.1 sbur	TRAR'S SIGNA		

SALISBURY MARYLAND

240, REC'D BY REGISTRAR DAMAY 1 . '59

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH 4907 Reg. Dist. No. director PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY Fied b. COUNTY COMICO MARYLAND PLO b. CITY OR TOWN (If outside corporate limits, write c. CITY Of TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 RURAL/ond give nearest town) sharuld d. NAME OF HOSPITAT UP not in hospital, give street address) IS RESIDENCE d. STREET ADDRESS OFF OR INSTITUTION ON A EARM? 2 YES INO ENINSO 5 NAME OF First 4. DATE Middle Last Month Day Yeni Filled DECEASED (Type or print) DEATH 19 COLOR OR RACE 9. AGE lin years IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX 7. MARRIED TO NEVER MARRIED 8. DATE OF BIRTH lost birthdoy) Months Days Hours WIDOWED | DIVORCED | campl 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY /1). BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) pup carbon 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME physician haurs 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT Address aftending ease within INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c). ONSET AND DEATH ā PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 420. **DUE TO** Conditions, if ony, which (6) been signed gove rise to immediate DUE TO per couse (o), stating the underlying couse lost burial-transit PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? 104 AT NO T 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) 200. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20e. PLACE OF INJURY/Home, form, 20f. (City or town) Month, Doy. Year 20d. INJURY OCCURRED (County) (Stote) foctory, street, office bldg., etc.) 0, m. While Not while 19 of work p. m. of work 1954, that I last saw the deceased attended the deceased from alive on and that death accurred at. filter the causes and an the date stated above. DATE SIGNED ADDRESS (Street ACTUAL SIGNATURE DIREC shauld FUNERAL I PHYSICIAN'S NAME (Type) O 220. BURIAL, CREMATION, 22b. DATE THEREOF 22d. LOCATION (City, lown, or county) 22c. NAME OF CEMETERY OR CREMATORY (Stote) REMOVAL (Specify) 0 23. FUNERAL DIRECTOR'S SIGNATURE 24b. REGISTRAR'S SIGNATURE **ADDRESS** 24a. REC'D BY REGISTRAR arthur S. Know VS A15 (4) 15M 9/58

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	STATE DEPARTMENT OF HEALTH—BAL	TIMORE,	18
4908	CERTIFICATE OF DEATH		

Reg.	0	4	8	9	8
17.00.25	DIST	. P	10.		

1. PLACE OF DEATH • COUNTY Wicomico	MARYLAND	2. USUAL RESIDENCE (W o. STATE Maryl:		. If institution b. COUNTY		before admis	sion)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (IF	outside corporale li	mits, write RI	URAL ond giv	ve nearest low	n)		
Salisbury	1 month	Cambrigge 09/3.2							
d. NAME OF HOSPITAL (If not in hospital, give street or Institution Deer's Head State Hosp	oddress) Dital	d. STREET ADDRESS 205 Fran	nklin Str	eet		e. IS RESIDENCE ON A FARM? YES NO			
3. NAME OF First DECEASED (Type or print) Harry	Middle H-	Bromwell	4. DATE OF DEATH	April		Day 17	Yeor 19 59		
5. SEX 6. COLOR OR RACE 7. MAR White WIDOW		8. DATE OF BIRTH 9/14/1.881.	9. AG	E (In years I birthdoy) 7 yrs.	-	YEAR IF UND			
10a. USUAL OCCUPATION (Give kind of work done during WA Dividical Fig. even if retired)	EAF OOD SINESS OR INDU	STRY 11. BIRTHPLACE (Stote Marylar			12. CITIZ	EN OF WHAT	COUNTRY		
13. FATHER'S NAME John Bromwell		14. MOTHER'S MAIDENK	CHOWN						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. [Vas. na. or M(G)wn) [If yes, give wor or dates of service]	UNKNOWN 17 NO. 17.	NFORMANT Hospita	al Record	S Addr	ess				
A Fine of	oronary thrombo	osis				INTERVAL BE ONSET AND Sudd	DEATH		
gove rise to immediate couse (a), stating the under-	rterioscleroti	c cardiovascu	dar disea	ıse		?			
Jying couse lost. (c)					EN IN PART 1	PERFC	AUTOPSY PRMED?		
	CRIBE HOW INJURY OCCURRE	U. (Enfet holure of injury in	Port 1 or Port II of	item IB.j					
20c. TIME OF INJURY Month, Doy, Year 20d. I Hour o. m. 19 White of wor	Not while foo	ACE OF INJURY (Home, form ctory, street, office bldg., etc	n, 20f. (City or tov	vn)	(Co	unty)	(State)		
21. I certify that I attended the decease alive an April 17 195 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) L. V. Maldve,	9, and that death	accurred at 3:48	PM, from the ADDRESS (Street, of Head Sta	causes a ity or town, s ate Ho	nd on the	date state	deceased ed above ATE SIGNED 7/59		
220 BURIAL CREMATION, 22b. DATE THEREOF APRIL 20 19	22c. NAME OF CEMETERY OF		22d. LOCATION ((Stot MARYL			
23. LECOMPTE FUNERAL SERVICE	CAMBRIDGE M	A DVT A NTO I	D BY REGISTRAR	24b. REGIS	TRAR'S SIGN	ATURE	A IND		

AND THE RESERVE AND THE PARTY NAMED IN COLUMN THE RESERVE OF THE PROPERTY OF within 24

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

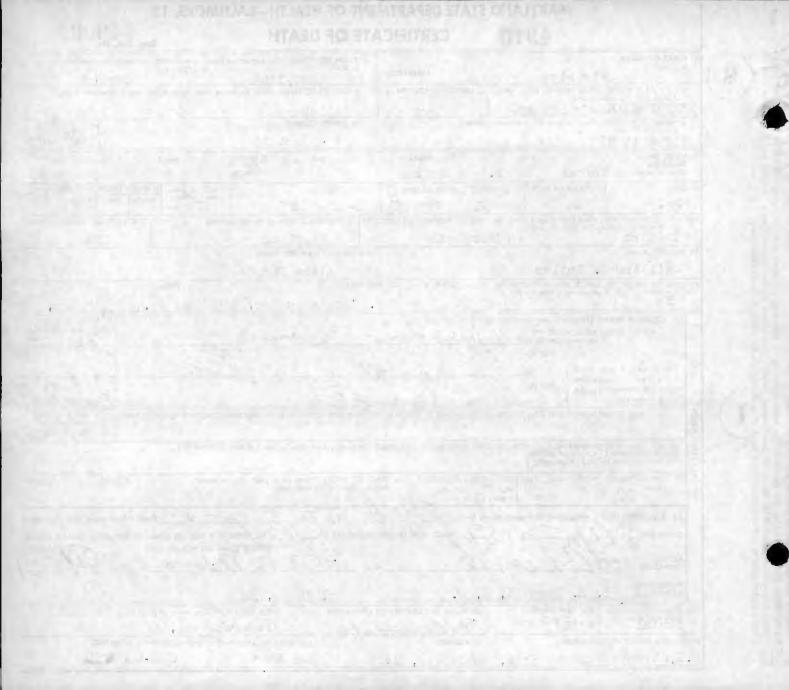
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY	Wicomico		MARYLANE	11 0	VAL RESIDENCE (STATE Marv		d lived. If instituti b. COUNTY	on: Residence be		ion)
RURAL and give no	M Salisbur	7	LENGTH OF STAY IN 18	113		If autside corpo	role limits, write R			n)
d. NAME OF HOSPIT OR INSTITUTION 810 East R	AL (If not in hospital, gi	ve street add	ress)		STREET ADDRESS		4-14-1		_	SIDENCE FARM?
3. NAME OF DECEASED (Type or print)	Firs Thomas	E.	Middle Butler		Lost	4. DATE OF DEATH	Mon 4	th C	0	Yeor 19 59
5. SEX Male	4.4	7. MARRIED	NEVER MARRIED DIVORCED		OF BIRTH	91	9. AGE (In years last birthday) 67 yrs.	Months Days	R IF UND	
Minister	IN (Give kind of work ding life, even if retired)		D OF BUSINESS OR INC	OUSTRY 11	BIRTHPLACE (SIGNATURE)	_		12. CITIZEN	OF WHAT	COUNTRY
	E. Butler			14. N	Alice	N NAME Nickles				
15. WAS DECEASED EVER	R IN U. S. ARMED FORC If yes, give war or dates of se			INFORMA		tler, 8	Addi 10 East 1		isbur	y, Md
Conditions, if of gove rise to in cause (o), stating lying cause lost.	he under- the under- (c).	ITIONS CON	Section of the sectio	EL STROPRE	LATED TO THE TER	RMINAL DISEASI	CONDITION GIV	5	PERFO	fond
	CAUSE OF DEATH		E HOW INJURY OCCUR							
20c. TIME OF INJURY Hour o. m. p. m.	Manih, Day, Year	While of work	Not while	PLACE OF foctory, sire	INJURY (Home, for eet, office bldg.,	orm, 20f. (City etc.)	or town)	(County	')	(State)
ACTUAL SIGNATURE	attended the	1250	7_, and that dea	th occur	19 7 to red of A	ADBRESS (S)	the causes a reet, city ar rown,		ate state	
220. BURIAL, CREMATION REMOVAL (Specify)			C. NAME OF CEMETERY	OR CREMA		22d. LOCAT	ION (City, town, o		(Slot)	e)
23. FUNERAL DIRECTOR'S J.F.Stewart	SIGNATURE	ma C-	ADDRESS	7//		APR 1 6 "	RAR 24b. REGIS	STRAR'S SIGNATU		
TIT TO GETT O	E criter or 10	me, 58	TIBDULA, MO		DATE	MLU I O 3	13	Vinted A 74	mildle.	



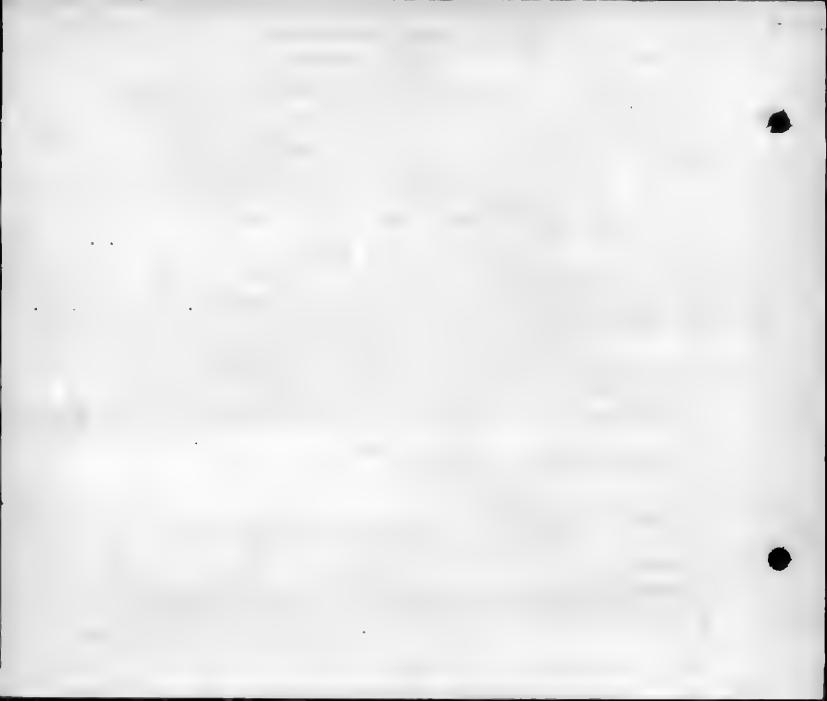
CERTIFICATE OF DEATH director Page 1. PLACE OF DEATH o. COUNTY p. STATE Wicomico MARYLAND Marvland death. erol b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 15 ä RURAL and give nearest town) Nanticoke Salisburv d. NAME OF HOSPITAL (If not in hospital, give street oddress) / d STREET ADDRESS OR INSTITUTION executed within 24 hours eninsula General Hospital .⊆ NAME OF 4. DATE Middle Lost OF DEATH (Type or print) 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5 SEX B. DATE OF SIRTH pletely WIDOWED [DIVORCED [Nis le White during most of working life, even if retired) Railway Carpenter Boat Maryland Duo 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME physicion Henry Briscoe Annie Murray 17 INFORMANT 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. Na ottending 18. CAUSE OF DEATH [Enter only one couse per line for (o), PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) requires that the 4.20.1 DUE TO á ò Conditions, if ony, which gned gove rise to immediate 2 **DUE TO** couse (a), stating the underlying couse lost. burial-transit 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, 20d. INJURY OCCURRED Doy, Year factory, street, office bldg., etc.) o. m While Not while of work of work p. m 21. I certify that I attended the deceased fram, buri alive on and that death occurred at. ACTUAL SIGNATUR 冒 P PHYSICIAN'S NAME (Type HOSPITAL FUNERAL Nanticoke Richard H. Saunders 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY REMOYAL (Specify) Turners Cem. 0 ADDRESS 24g. REC'D BY REGISTRAR 23. FUNERAL DIRECTOR'S SIGNATURE DATE APR 2 4 '59 VS A1S (4) valve

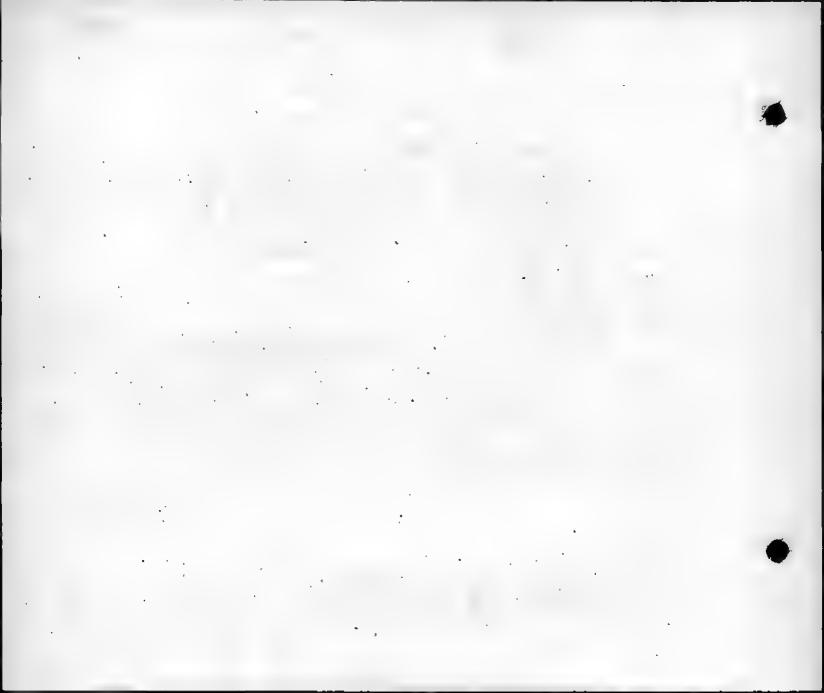
04901 Reg. Dist. No. 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. COUNTY Vicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) e, IS RESIDENCE YES | NO | To Month Day Yeor 19 9. AGE (In years lost birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Doys Hours YEL. 12. CITIZEN OF WHAT COUNTRY? 100 USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) U.S Address sbuev INTERVAL BETWEEN ONSET AND DEATH PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO N 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20e. PLACE OF INJURY (Home, form, 20f (City or town) (Slote) (County) 19.59, that I last saw the deceased 4512M, from the causes and an the date stated above. ADDRESS (Street, city or town, stole) DATE SIGNED 22d. LOCATION (City, lown, or county) (Stole) Nanticoke A.Bryland 246. REGISTRAR'S SIGNATURE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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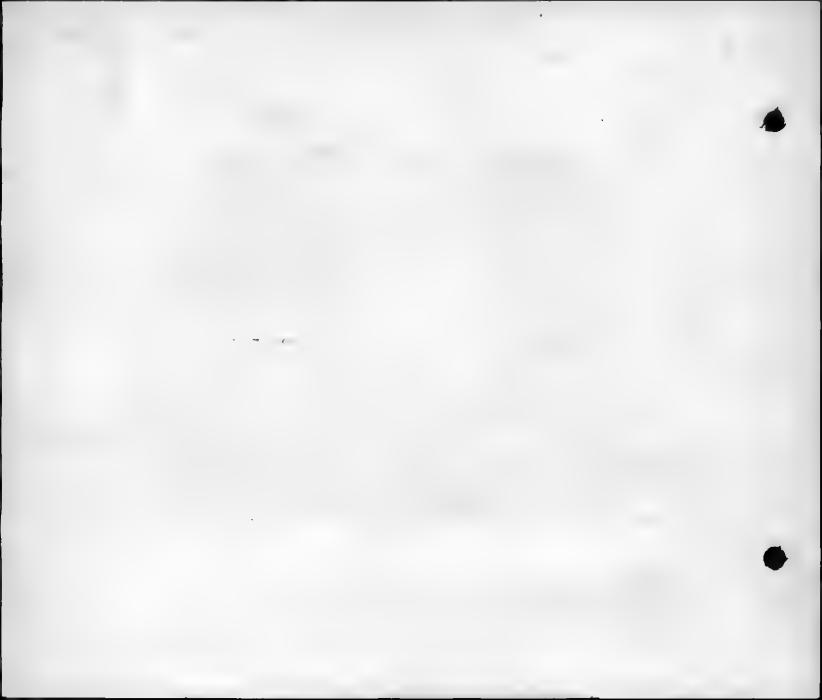
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				STATE	DEPAR	RTME	NT OF HEA	ALTH	I-BAL	TIMOR	E, 1				
		491	3	(CERTIF	ICA	TE OF DE	ATH	1			Reg. D	149 14. No.	03	
1.	PLACE OF DEATH O COUNTY W1	comico			MARYL	11	2. USUAL RESIDEN o. STATE Ma	ryl.	-	d lived. If in b. COI			nce befo		ion)
	b. CITY OR TOWN (If RURAL and give nea	autside corporate lim	its, write	c. LENGTH	OF STAY IN	V 1Ь	c. CITY OR TOV	VN (If o	ulside corpo	orate limits, w	rite RU	JRAL and	give nec	zrest tawr	1)
	Salisbur			39	days		> Pitt	svi.	Lle						
	or institution Deer's	ead State		,			d. STREET ADD	RESS							FARM?
	NAME OF DECEASED (Type or print)	Paul			Middle Gladys	3	Coope	r	4. DATE OF DEATH	Ap	Mont		6		Yeor 19 59
4		6. COLOR OR RACE	7. _{MA}	RRIED 🔼 NEV	ER MARRIED	B B	DATE OF BIRTH	-		P. AGE (In)	rears				R 24 HRS.
_	Female	White		WED []	DIVORCED		1/28/191	-		41	yrs.	Months	Days	Hours	Min
)o	 USUAL OCCUPATION during most of working 	N (Give kind of working life, even if retired	done 10t	b. KIND OF BL	JSINESS OR	INDUSTI	RY 11. BIRTHPLACE	(Stole	or foreign c	ountry)		12 C	ITIZEN O	F WHAT	COUNTR
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S.	George De	വന് ത					14 MOTHER'S MA								
-	WAS DECEASED EVER		ccca la	SOCIAL SEC	TIDITY NO	157 1515	_		aroon						
Y .	t, no. or uning-in] (If	yes, give war or dates of		212-1	4-47	142	ORMANT HO	spit 	al Re	cords	Addre	P35			
	18. CAUSE OF DEAT		use per	line for (o), (b), ond (c).]									RVAL BE	
	PARI I. DEAII	H WAS CAUSED BY: IMMEDIATE CAUSE (c	1	Absc	ess of	rig	ht lung							?	DEATH
	772X	DUE TO													
	Conditions, if any gave rise to sm]	Chro	nic pr	eumo	nitis							?	
	cause (a), stating the														
5	PART II OTHE	R SIGNIFICANT CON		CONTRIBUTION	NG TO DEAT	H BUT N	OT RELATED TO TH	E TERMI	NAL DISEAS	E CONDITION	4 GIVI	N IN PA	RT 1(o) 1	9. WAS	AUTOPSY
		Bronchial	Ast	hma											RMED?
	20g ACCIDENT WAS OR CONTRIBUTING C (IF EITHER, NOTIFY M	UNDERLYING [] CAUSE OF DEATH REDICAL EXAMINER)	20b. DE	SCRIBE HOW	INJURY OCC	CURRED.	(Enter noture of in	ury in F	ort I or For	t II of item 18	3.)				
MEDICAL	20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Ye	20d. While		hile	Oe. PLAC fecto:	E OF INJURY (Horry, street, office blo	e, form Ig., etc.	20f. (City	or town)			(County)		(Stote)
	21. I certify that alive on Apri		deced		Feb.		, 19 <u>59</u> , 1 occurred at 7	55A	M, fron		es q	nd an	last so the dat	le state	d abav
	ACTUAL SIGNATURE	V. hu	<u> Uh</u>	1			Dee			reel, city or 1 State			1		59
	PHYSICIAN'S NAME (Type)	L. V. Mal	ive,	M. D.			Sali	sbu	ry, M	arylan	d				
20	BURIAL EREMATION BEMOVAL (Specify)	226. DATE THEREO	54	22c NAME	OF CEMET	ERY OR	EREMATORY		28,100	TION ICITY IS	own, or	county)	-/	Z (Stote	1.
:3,	FUNERAL DIRECTOR'S	SIGNATURE		ADDRE	55/	. /			BY REGIST				IGNATUR	RE	
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o. S. TO DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If any delay is necessary, please	execute the certifie, writing the word "pending" in pencil in Item, 18. Give Pages 1, 2, and 3 to the funeral difference Page	2 15	7	or its designated agent, priar to burial, cremation, ar remaval, and in any every within 72 hours after death,	
	44.6				

	MEDICAL EXAMINER'S CERTIFICATE OF DEATH ()4904
t.	1. PLACE OF DEATH COUNTY SCIENCE (Where deceased lived If institution, Residence before admission) COUNTY SCIENCE MARYLAND DESCRIPTION COUNTY SCIENCE CO
1	b CITY OR TOWN (If outside corporate limits, will a RURAL and give nearest town) all for nearest town) A NAME ON HOSPITAL OR INSTITUTION (If not in haspital, give street address) A STREET ADDRESS ON A FARMI YES NO
	3. NAME CF DECEASED (Type or print) 5. SEX 6 COLOF OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9 AGE I'm years 15 UNDER 1YEAR IF UNDER 24 HVS foot print(or)
)	Male Negto WIDOWED DIVORCED 2 45 6 2 yrs Month Logs No. 100. USUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY during most of working life, even if retired) 13. ATHER'S NAME
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT (If yet, give war or datas of service) 18 CAUSE OF DEATH [Enter only one cause per l'ine for (o), (b), and (c).] PART 1. DEATH WAS CAUSED BY: (Interval extincted DISTERAD DEATH INTERVAL EXTINCTED IN
V	IMMEDIATE CAUSE (a) OUE TO Conditions, if any, which gave rise to immediate couse (a), staling the underlying couse last. (c)
*	PART 11, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY REFFORMED? YES NO 200 EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING 200 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 13 of item 18)
	CAUSE OF DEATH. 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, 20f. (City or fown) (County) (State) Hour o, m
	21. I certify that I tack charge of the remains described above, held an Autopsy , Inspection . Inquiry , and in my opin an death resulted from: Natural causes . Accident , Suicide , Hamicide , Undetermined manner . ACTUAL SIGNATURE
ne ne	EXAMINER'S NAME (Type) Philip A, Instead of the policy of the puty medical examiner Deputy medical exa
	23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS ADDRESS ADDRESS DATE MAY E 159 CARTURE THREE ADDRESS DATE MAY E 159 CARTURE THREE ADDRESS DATE MAY E 159



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 haurs after death. Page 4 serol director. ald be filed with moy be retained to hospital or attending physicion. TO FUNERAL DIRE. R: After this cert ficate has been signed by the attending physician and campletely filled in by P. page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 sho the registrar prior to burial, crematian, or removal, and in any event within 72 haurs after death

VS A1S (4) 1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4915 CERTIFICATE OF DEATH

() 4905 Reg. Dist. No.

1		PLACE OF DEATH G. COUNTY, g. STATE	ere deceased lived. If institution: Residence before admission)
Ĵ		MARYLAND STATE MARYLAND MARYLAND MARYLAND	27d b. COUNTY WOLCESTOF
	Ь	b. CITY OR TOWN (If autside corporate limits, write c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If a RURAL and give negrest town)	utside carporate limits, write RURAL and give nearest town)
		Jahls buly	C. T. Six.
		d. NAME OF HOSPITAL (If not in happing), give street address) OR INSTITUTION d. STREET ADDRESS	e. IS RESIDENCE
3	P	Peninsula Meneral EDGEWAT	FR. AUF YES NO X
	3. N		4. DATE Month Day Year
		DECEASED	OF /! /
		S. SEX 6. COLOR OR RACE 7 MARRIED NEVER MARRIED 1 8 DATE OF BIRTH	9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS
	~2	Bracky White WIDOWED DIVORCED 1 1 AV 27 1	(1 a (last birthday) Months Days Hours Min
	10a	7774.00	or foreign country) 12. CITIZEN OF WHAT COUNTRY?
	100	during most of working life, even if, retired)	
	32		LAND U.S.A.
	13. 1	13. FATHER'S NAME	
	_ \	GRANVILLE CROPPER JR. MANA	HUPSON
\		15, WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. INFORMANT (Yes. noor uphtnown) (If yes. give wor or dates of service)	Address (10
)) YOS IMR. GRANVI	LLE CROPPER JR UCEAN CIT
,		18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
		PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (g) DEREV TERRY COL	ca. Coultr
		237x DUE TO	
		Conditions, if any, which)	
		gave rise to immediate OUE TO	
		lying couse last.	
	Z	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMI	NAL DISEASE COND TION GIVEN IN PART 1(a) 19 WAS AUTOPSY
70. se	CATION	ATIC	PERFORMED? YES [] NO []
	CERTIF	GR CONTRIBUTING CAUSE OF DEATH Contributing Cause of Death	
			, 20f (City ar town) (County) (State)
	MEDICAL	Hour a.m. While Not while factory, street, office bldg., etc.	
	Σ		
		and the same of th	4-14, 1959, that I last saw the deceased
			M, fram the causes and an the date stated above.
			ADDRESS (Street, city or fown, state) DATE SIGNED
a		SIGNATURE (L.C. Clu, S. T. C. C. M.D.)	wadding and 7 165
L		PHYSICIAN'S	,
		NAME (Type)	
	22a.	220. BUR AL, CREMATION, 22b DATE THEREOF REMOVAL (Specify)	22d LOCATION (City, town, or county) (State)
		BURIAL 4/16/59 UDD FELLOWS	1315HOPYILLE MD
	23, 1		D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE
	_/	Ama A. Bulley Sellin Mid. DATE 1	APR 2 0 '59



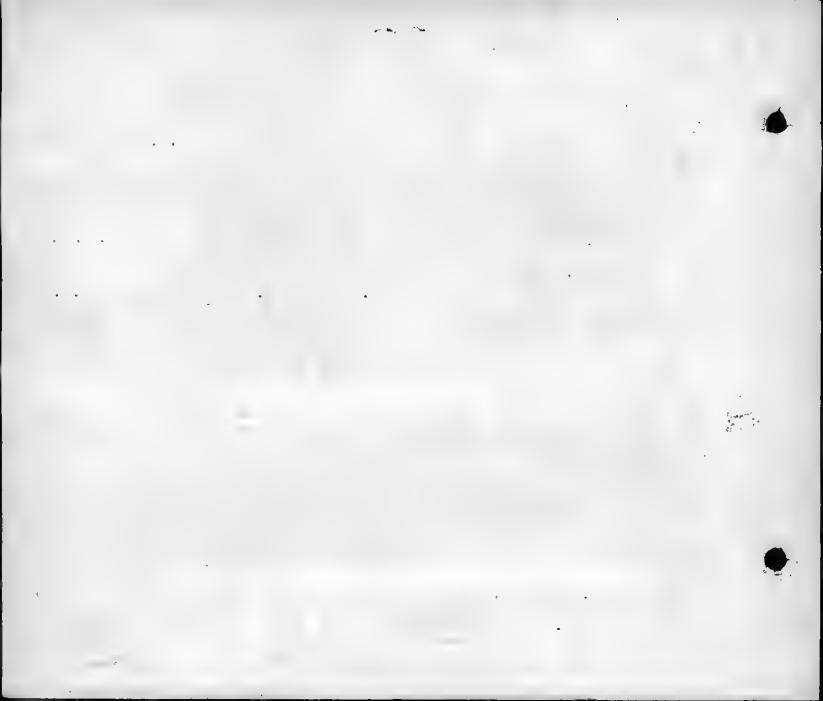
915	CERTIFICAT	E OF DEATH

()4895 Reg. Dist. No.

	also NA Like									KAN DIN		
PLACE OF DEATH 6. COUNTY	Vicomico		MAR	- 11	2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Wicomico							
b. CITY OR TOWN (II	outside carporate limi	ts, write	c. LENGTH OF STAY	IN 1b	c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town)							
	· ·		three day	vs .								
d NAME OF HOSPITA	AL (If nat in hospital, g	ive street	oddress)	/			J 04.2 J				• 1	S RESIDENCE
Deer's	Head Stat	e Ho	spital			agsbo	oro Ro	ad (R.D	·# 3) YE	S 🔲 NO 🛴
NAME OF	Fir	st	Middle		Last		4. DATE		Mont	h	Doy	Yeor
(Type or print)	Martha	l	Kissa	n	Bello	as .	DEATH	Į.	lpri.	1	3	19 59
SEX	6. COLOR OR RACE	7. MARR	IED NEVER MARRI	ED 🔲 B.	DATE OF BIRTH			9. AGE (In	yeors			
Female	White	WIDOWE	DIVORCE	D 🗍	Februa	aryl9.	1862	97	yrı.	MacIhs 5	PA H	ours Min.
. USUAL OCCUPATIO	N (Give kind of work	done 10b.	KIND OF BUSINESS C	R INDUSTR	Y 11 BIRTHPL	CE (Stole o	or foreign-co	թսըիդ)		12. CITIZ	EN OF W	HAT COUNTRY?
None (He	ouse Work)	None		1	len je	ersev	LUY			U. S	- A-
FATHER'S NAME	0400011	./									-	
Thor	Thomas R Kissam Martha Gillingham											
WAS DECEASED EVER	IN U. S. ARMED FOR	CES? 16.	SOCIAL SECURITY NO	JZ INF	DRMANT _						- \ D	D //o
No "No" (" yet eve wor or dorm of service) Mrs. Adelaide K. Whipple (Daughter). Hospital Records - Salisbury, Ma											Mar	yland
		use per lin	ie for (o), (b), and (c)]							INTERVA	AL BETWEEN
, , ,	TH WAS CAUSED BY: IMMEDIATE CAUSE (6)	Ar	terioscler	ostic	- Card	iovas	cular	Dise	ase		Ye	ars
40.d.	DUE TO	,										
Conditions, if or	y, which }	Ar	terioscler	nsis	- Gener	al					Years	
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lying couse last.	ne under-	1										
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											P VE	ERFORMED?
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	CAUSE OF DEATH MEDICAL EXAMINER)				,	,,						
20c. TIME OF INJURY	Month, Doy, Yes			20e. PLAC	OF INJURY I	lome, form,	20f (City	or town)		(Co	unty)	(Stole)
p. m	19	ol work		, acidi	y, silver, office	ologi, elc.	1					
21. I cartify the	at Lattended the	decense	d from 4/1	/59	. 19	10 4/	/3/59	1	0	that Lla	et cow	the decement
1	18/59											
0.1170	1			dediti 0	ccorred or.						oule :	DATE SIĞNED
ACTUAL SIGNATURE	IV. Was	(du	1 ,	AA I	1						4	/4/59
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NAME (Type)	L. Maldve	, M.	D	De	er's H	ead	State	Нов	pit	al-S	alis	bury, M
		F										(Stole)
"Fartal"	Apr. 5	159	Wicomic	o Mei	norial	Par	k S	dal1s	bur	y, Ma:	ryla	nd
FUNERAL DIRECTOR'S			ADDRESS			24a. REC'D	BY REGIST	RAR 24E	REGIS	RAR'S SIGN	MATURE	
HOLLOWAY (SALISBURY			DATEAPE						
	D. CITY OR TOWN (IN RURAL and give ne Salist d NAME OF HOSPIT. OR INSTITUTION DEED'S SEX Female O. USUAL OCCUPATION during most of work None (He FATHER'S NAME Tho: WAS DECEASED EVER PART I DEAT WAS DECEASED EVER PART I DEAT FATHER'S NAME Conditions, if or gove rise to in course (o), stating I lying course last. PART II. OTH 200. ACCIDENT WAS OR CONTRIBUTING (IF EITHER, NOTIFY) 201. I certify the clive on MACTUAL SIGNATURE PHYSICIAN'S NAME (Type) O. BURIAL, CREMATION REMOVED TO TOWN TO TOWN TO THE PHYSICIAN'S NAME (Type) O. BURIAL, CREMATION REMOVED TOWN TOWN TOWN TOWN TOWN TOWN TOWN TOWN	D. CITY OR TOWN (If outside carporate limit RURAL and give nearest town) Salisbury d NAME OF HOSPITAL (If not in hospital, gor institution) Deer's Head State NAME OF DECEASED (Type or print) SEX 6. COLOR OR RACE Female Usual occupation (Give kind of work of during most of working life, even if retired None (House Work FATHER'S NAME Thomas B. Kiss WAS DECEASEDEVER IN U. S. 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Date thereof the pemoval (Special Cause)	D. CITY OR TOWN (if outside carporate limits, write RURAL and give neorest town) Salisbury d NAME OF HOSPITAL (if not in hospital, give street of OR INSTITUTION Deer's Head State Hospital (if year give street of OR INSTITUTION) NAME OF DECEASED (Type or print) SEX 6. COLOR OR RACE Female Unite White Widower Whome (House Work) FATHER'S NAME Thomas B. Kissam WAS DECEASEDEVER IN U. S. ARMED FORCES? If year give were or dates of service) IB CAUSE OF DEATH [Enter only one couse per limited of the print of th	b. 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I certify that I attended the deceased from 19 of work of work ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) L. Maldve, M.D. 0. BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify) Apr. 5 / 59 Wicomico Medical PART II. COMMETCRATION, 22b. DATE THEREOF REMOVAL (Specify) Apr. 5 / 59 Wicomico Medical PART II. COMMETCRATION, 22b. DATE THEREOF REMOVAL (Specify) Apr. 5 / 59 Wicomico Medical PART II. COMMETCRATION, 22b. DATE THEREOF REMOVAL (Specify) Apr. 5 / 59 Wicomico Medical PART II. COMMETCRATION, 22b. DATE THEREOF REMOVAL (Specify) Apr. 5 / 59 Wicomico Medical PART II. COMMETCRATION, 22b. DATE THEREOF REMOVAL (Specify) Apr. 5 / 59 Wicomico Medical PART II. COMMETCRATION, 22b. DATE THEREOF REMOVAL (Specify) Apr. 5 / 59 Wicomico Medical PART II. COMMETCRATION Apr. 5 / 59 Wicomico Medical PART II. COMMETCRATICAL PART III. COMMETCRATICAL ACTUAL PHYSICIAN'S RURAL ACTUAL PHYSICIAN'S RURAL ACTUAL PHYSICIAN	D. 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DATE OF BIRTH February 19 Pebruary 19 None (House Work) None None (Ho	D. CITY OR TOWN (if outside corporate limits, write RURAL on Give Series body) S. ALTSDURY d. NAME OF STATE MARYLAND NAME OF STORY IN It is street oddress) d. NAME OF STORY IN It is street oddress) NAME OF FIRST NAME OF FIRST NAME OF FIRST NAME OF STORY IN IT IS STREET ADDRESS SEX G. COLOR OR RACE O. SULAL OCCUPATION (Give kind of work done lob. KIND OF BUSINESS OR INDUSTRY IT BIRTHPUGE Sighe or formage during most of working life, even if retired) None Thomas B. Kissam Martha Was DECEASED EVER IN U. S. ARMED FORCES? Inc. SOCIAL SECURITY NO INFORMANT IN ITEMPORAL RECORD NOTE OF BATH [Enter only one couse per line for (o), (b), and (c)] PARTI DEATH WAS CAUSED BY: PARTI OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEAS OR INDUSTRY IN ITEMPORAL FOR INJURY IN ITEMPORAL IN IT	b. 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TO MOSFILAL OR ALLESTANDER OF A PROPERTY OF THE ACTION OF THE ACTION OF COMPLETE AND A PARTIES OF THE ACTION OF TH TO HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 4 VS A15 (4) 15m H/SS

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

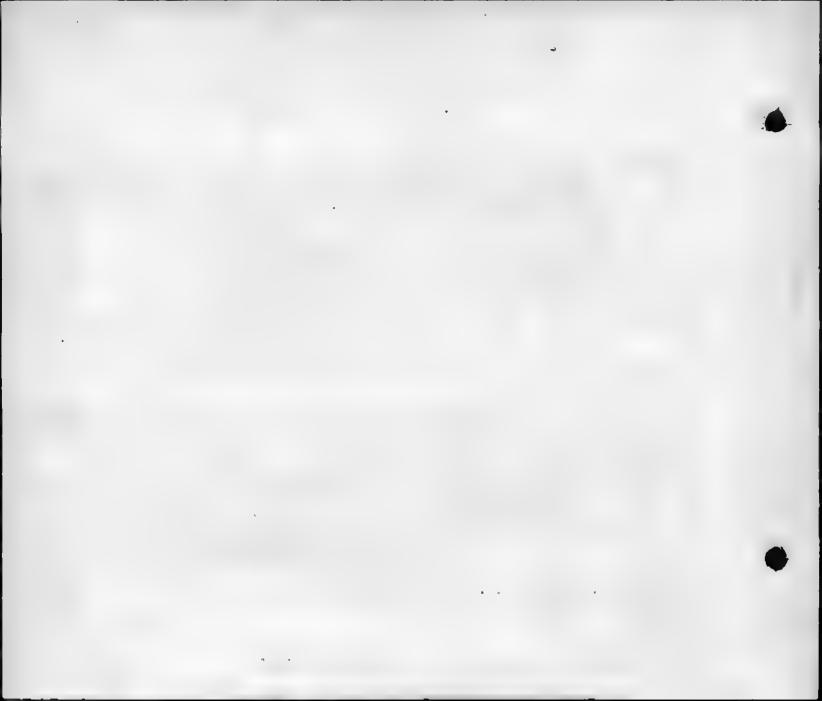
	CEDTIEICATE	OF	DEATH
017	CERTIFICATE	Ur	DEAIL

04906

Reg. Dist. No. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) . COUNTY Wicomico Maryland b. COUNTY Somerset MARYLAND b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give negres) town) RURAL and give nearest town) Salisbury, Maryland 10mo. 17 days Oriole, Maryland d. NAME OF HOSPITAL (If not in hospital, give street address) d STREET ADDRESS e. IS RESIDENCE OR INSTITUTION Deer's Head State Hospital YES NO NAME OF Middle 4. DATE Month Dov Beullah Cordellia Crosswell. April DEATH [Type or print] 8 DATE OF SIRTH 9. AGE (In years IF UNDER 1 YEAR IF LINDER 24 HPS 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Months Female White WIDOWED TX DIVORCED [Mar. 22, 1881 100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

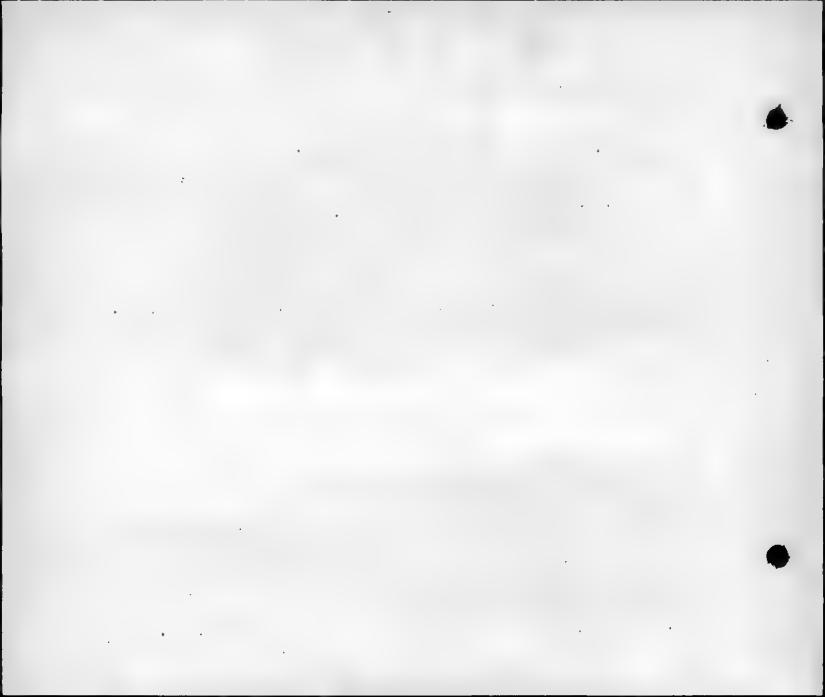
HOUSEWIFE

Maryland 12. CITIZEN OF WHAT COUNTRY? USA 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Zadoc Phoebus Roberta Jones 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Address Hospital Salisbury, Maryland unk unk Records INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] PART I, DEATH WAS CAUSED BY:
IMMEDIATE CAUSE In) Coronary occlusion 6 hr. Hypertensive Arteriosclerotic Cardivascular disease Canditions, if ony, which gove rise to immediate DUE TO Couse (o), stoting the under-Tring couse last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? YES TO NO KT 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part I or Port II of item 18) MEDICAL 20e. PLACE OF INJURY (Home, form, 20f. [City or town) 20c. TIME OF INJURY 20d. INJURY OCCURRED (County) (Stote) foctory, street, office bldg., etc.) While Not while of work Apr. 19, 21. I certify that I attended the deceased from June 2, . 19.59 that I last saw the deceased alive on Apr. 19, , and that death accurred at 2:40 AM, from the causes and an the date stated above. ADDRESS (Street, city or lown, state) DATE SIGNED Salisbury, Maryland ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) V. Juerman. M.D. 220. SURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, town, or county) HEMPYA E Specify) Oriole Oriole, Maryland 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Orthur S. Harra





MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 4966 Reg. Dist. No. 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) **b** COUNTY Wicomico c CITY OR TOWN (If outside corporate limits, write RURA) and give nearest town) e IS RESIDENCE YES NO IX Month Yeor 12th 19 50 IF UNDER 1 YEAR IF UNDER 24 HRS Months Hours 12. CITIZEN OF WHAT COUNTRY? USA Address Delmar, INTERVAL BETWEEN ONSET AND DEATH PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO D (County) (State) 2 1942, that I last saw the deceased and that death occurred at LAM, from the causes and an the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 22d LOCATION (City town, or county) (Slote) Md. 24b REGISTRAR'S SIGNATURE



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certification is made and in penaltial in limit 18. Give liages 1, 2, and 3 to the funeral direction. Page 4 should be formed to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained to 1. Files.

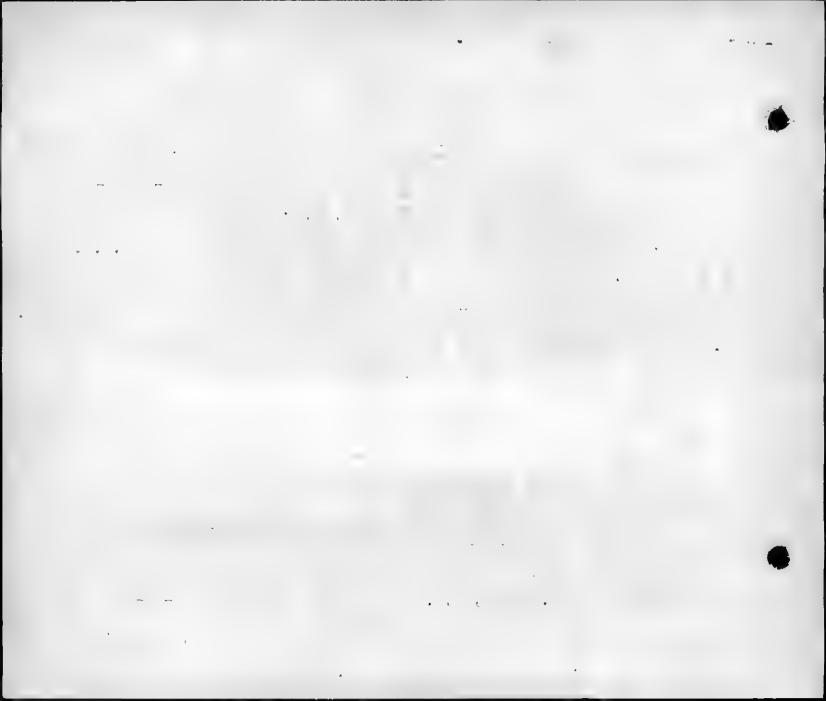
TO FUNERAL DIR WIR. Page 3 should be used as a buriol-transit permit. File pages 1 and 2 with the State Boon 2 of Health, at its designated agent, prior to burial, cremation, at removal, and in any event within 72 hours after death. 4 should be for

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VS. A15ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 AND A MEDICAL EXAMINER'S CERTIFICATE OF DEATH ()4909

	_ 3010					K	eg. Dist. No.				
1. PLACE OF DEATH			34	2. USUAL RESIDENCE (Where deceased live	d. If institution:	Residence befo	pre odmission)			
0. COUNT	Wicomico		MARYLAND	Virginia b. COUNTY							
b. CITY OR TOWN and give nearest lov	(If outside corporate limits, write R)	JRAL	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (limits, write RUR.	AL and give ne	torest town)			
Salis	bury				Chincote	acua .	: 5,				
d. NAME OF HOSP	ITAL OR INSTITUTION (IF I	at in hospit	ol, give street address)	d STREET ADDRESS		0		ON A FARM?			
	la General	Hos	oital	North M	Main Str	eet		YES NO 3			
3. NAME OF DECEASED	First		Middle	Lost	4. DATE OF	Month	Doy	Yeor			
(Type or print)	Joseph		Γ	errickson	DEATH	11-	11-	19 59			
5. SEX	6. COLOR OR RACE 7	MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AG	book bod on A		IF UNDER 24 HES			
WM	W	IDOWED [DIVORCED [Oct. 16, 190		oll yes Mo	nths Days	Hours Min			
10a USUAL OCCUPAT	ION (Give kind of work dor- ing life, even if retired)	10b. KIN	ID OF BUSINESS OR INDUS			1	2. CITIZEN OF	WHAT COUNTRY?			
Ret. Co.	ast Guard			Virgini	la		U.S.	Δ.			
13. FATHER'S NAME			-	14. MOTHER'S MAIDEN							
Frank L	. Derrickso	n		Emma Wat	tson						
15. WAS DECEASED E	VER IN U S. ARMED FORCE		CIAL SECURITY NO. 17.	INFORMANT		Address		· -			
Yes [1	World War 2	22	7-34-3310	Biel Tex	sec Seman	- Chir	cotea	gue, Va,			
18 CAUSE OF DE	ATH Enter only one couse	per line far	(a), (b), and (c)	. 1_3	-3-2	_		VAL BETWEEN T AND DEATH			
PART I. DE	ATH WAS CAUSED BY: IMMEDIATE CAUSE (6)	Ce	erebral ede	ma.			ONSE	Sudden			
322.0	DUE TO										
Conditions, if		Ac	oute alcoho	lism				Hours			
	gove rise to immediate couse										
(o), stoting the	Underlying (c)										
Z PART II, O	THER SIGNIFICANT CONDIT	IONS CON	TRIBUTING TO DEATH BUT	NOT RELATED TO THE TERM	INALDISEASE CON	DITION GIVEN II	N PART 1(0) 19	. WAS AUTOPSY			
XX							Y	EST NO			
200. EXTERNAL CAPPRIMARY OF COLOR	DNTRIBUTING 🔲	DESCRIBE H	IOW INJURY OCCURRED	Enter noture of injury in Fa	rt I or Port II of item	18)	1				
3 20c TIME OF INJ	URY Month, Day, Year	20d IN	URY OCCURRED 20e PL	ACE OF INJURY (Home, for	m. 120f. (City or tow		(County)	(State)			
Hour s.m		While of work	Not while fac	tory, street, office bldg., etc	.)		, , , ,	,			
21. I certify	that I took chorge o	f the rei	moins described ab	ove, held an <u>Autop</u>	y inspec	tion Ir	iquiry 🐴	and in my			
opinion death	resulted from: No	tural ca	uses 🔼 , Accident	, Svicide ,	Homicide 🔲.	Undetermin	red monner				
	E 05	0									
ACTUAL	and	17		_M.D. CHIEF MEDICAL E	XAMINER 🗍			DATE SIGNED			
EXAMINER'S	T 7 T 7)	ASSISTANT MEDIC	AL EXAMINER	1	r'0				
NAME (Type)	Earl L. R	oyer	M.D.	DEPUTY MEDICAL	EXAMINER A	4-17	-59				
220 BURIAL CREMATI	ION, 226. DATE THEREOF	27	C. NAME OF CEMETERY O	R CREMATORY	22d LOCATION	City, town, or cor	unty)	(State)			
Burial	April 14.	59		netery	Oak Ha	ll, Vir	ginia				
23 FUNERAL DIRECTO	R'S SIGNATURE		ADDRESS	24a REC		246. REGISTRAI		E .			
William	6. Selys	Ch	incoteague	Va. DATE	PR 3 0 '59	anth	2 8 Ken	M			
	,			the state of the s							



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HOLLOWAY & COMPANY

er ince	1			4919		CERT	IFIC/	ATE OF D	EATH		Reg. Dist.	4910
Page director	웹)		ACE OF DEATH	Vicomico		MA	RYLAND	II O. STATE .	ENCE (Where deceo	ed lived Il institut b COUNT	Wicon Residence	before admission)
death:		1	RURAL and give no	outside corporate limi grest town) Salisbury	ts, write	c LENGTH OF STA	Y IN 16		own (II outside cor	orote limits, write		
by the	у×`.		NAME OF HOSPIT	At (If not in haspital, g Pen Gen H	ospi	ddress) tal		d. STREET AD			St	e. IS RESIDEI ON A FAI YES N
illed in			IAME OF ECEASED Type or print)	FREDERI	sf	Midd AUGUS		Lost DISHARO	4. DATE	Ma AP	nth RIL	Day Yeor 28th 19
d within pletely fi rs. Pag		5. S	ex lale	6 COLOR OR RACE White	7. MARRII WIDOWEE		RIED 🗌	B. DATE OF BIRTH		9 AGE (in years lost buthday)		YEAR IF UNDER 24
ond completed population papers		F	etired (ON (Give kind of work ing lile, even if refired arpenter		ind of Business uilder	OR INDU		omoke, Ma			N OF WHAT CO
icate be siscian o ive carbi urs after				lney Dish					maiden name ry Ann M	ason		
h certifi ling phy se remo n 72 hou		15 (Yes	Unk	R IN U. S. ARMED FOR If yes, give wor or dotes of s	ervice]		IAI	1101 N.	rick A.D.	isharoğ	n(Jr.) alisbu	Son Md.
the offer the offer Then pleo				TH [Enter only one co TH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO	1	phorto	ton	no of	Medias	Tenum	,	INTERVAL BETWI ONSET AND DE HOLLING
equires the n. signed by t permit. d in ony e			Conditions, if or gove rise to in cause (o), stating t lying cause last.	the <u>under-</u>								
he law re physicia nas been riol-tronsi noval, on	2	CATION	PART II OTH) (c ER SIGNIFICANT CON		ONTRIBUTING TO D	EATH BUT	NOT RELATED TO	THE TERMINAL DISEA	SE CONDITION GI	VEN IN PART 1	(o) 19 WAS AUT PERFORME YES X N
tending ifficate if the burner		L CERTIF	20g ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	S UNDERLYING [] [] CAUSE OF DEATH MEDICAL EXAMINER)	206. DESCI	RIBE HOW INJURY	OCCURRE	D. (Enter nature of	injury in Part I ar Po	et II of item 18.)		
PHYSIC tol or of this cert or use as remotiar		MEDICA	20c. TIME OF INJUR' Hour o m p. m	Y Month, Day, Yes	27 20d INJ While at work	Not white at work	20e. PL/ foo	ACE OF INJURY IH clory, street, office	ome, form, 20f. (Co bldg., etc.)	ly or lown)	(Cou	nty) (
the hosping: After			21. I certify the	at I attended the	deceased, 19.2	d fram. Fi	death	accurred at	2:00P _M , fro	m the Causes	and on the	date stated
DIRE DIRE	1		ACTUAL SIGNATURE	red M. C	Jus	mes		M.D. Sals	Strong,	mol.		4/29
SPITAL be reto NERAL 3 shou	- 1	220	PHYSICIAN'S DY		Gæm	22c NAME OF CE	METERY O	*	sion St.	Salisb		
o HO may o Fur poge			REMOVA (Spicily)	Apr.30,				emetery		isbury,		and (Stole)

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12. CITIZEN OF WHAT COUNTRY USA Jr.)Son isbury,Md. GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED?
YES 100 1 (County) (Stote) 2, that I last saw the deceased s and on the date stated above. vn. slote) bury, Many n, or county) (State) Maryland 24b. REGISTRAR'S SIGNATURE 24o. REC'D BY REGISTRAR SALISBURY MARYLAND DATEMAY 1 arthur S. House '59

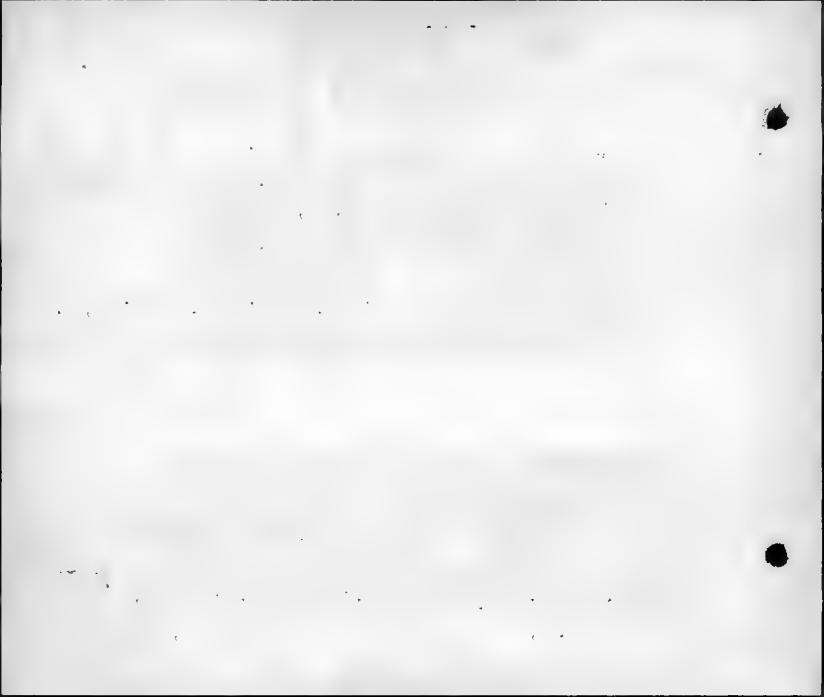
()4910 Reg. Dist. No.

e. IS RESIDENCE ON A FARM? YES NO-E

28th 19 59

IF UNDER I YEAR IF UNDER 24 HRS

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		MARYL	AND	STATE DEPAR	TME	NT OF HEALT	H-BAL	TIMORE, 1	8 ,,	4011	
		492	2	CERTIF	ICA	TE OF DEAT	Н		Reg. Dist.	191) No.	L
	PLACE OF DEATH o. COUNTY	Wicomico		MARYLI	- 11	2. USUAL RESIDENCE (W. o. STATE Mary	there deceased	d lived. If institution b. COUNTY		efore odmi	
	b. CITY OR TOWN RURAL and give i	(# outside corporate limit nearest town) Salisbur		c. LENGTH OF STAY IN	1 15	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown) Selisbury					
	d. NAME OF HOSP OR INSTITUTION	ITAL (If not in hospital, gi 842 W. Ma				d. STREET ADDRESS 842		lain St		ON.	A FARM?
	NAME OF DECEASED (Type or print)	REBEC	CA	Middle EMILY		ELLIS	4. DATE OF DEATH	APRII		o _{oy} th	Yeor 19 59
·	Female	White	WIDOW		_ -		1866	10st birthdoy) 92 yrs.	Months Doy		7
10c	during most or wo	ON (Give kind of work of rking life, even if retired) OPK	one 10b	kind of Business or None		Snow H1		aryland		U S	T COUNTRY
13.	Tather's NAME	Flemming				14. MOTHER'S MAIDEN Rebecca					
15. (Ye	WAS DECEASED EV	ER IN U. S. ARMED FORE	ES? 16	SOCIAL SECURITY NO.	Mrs	Nick Howa	ard(Gi		ähter Marvl) 842 and	W.
		immediate DUE TO	CA	re for (o). (b). and (c).	ten	Clusion, Schoosis	out	7	111	Sym	ETWEEN D DEATH MELO
THICATION	20o. ACCIDENT W	HER SIGNIFICANT CONE				OT RELATED TO THE TERM			N IN PART 1(o	PERF	AUTOPSY ORMEU?
MEDICAL CERTIFICATION	(IF EITHER, NOTIFY 20c. TIME OF INJU Hour o.m. p. m.	G LI CAUSE OF DEATH Y MEDICAL EXAMINER) RY Month, Doy, Yea	r 20d. Ih White at work	NJURY OCCURRED 20 Not white of work	De. PLAC	E OF INJURY (Home, forry, street, office bldg., etc.	m, 20f. (City	or town)	(Coun		(Stole)
	21. I certify to alive on Con-	hat I attended the	decease _, 1 <u>೪ ೪</u>		eath o	, 1917 , to (ccurred ab: 00F	M, from	1915 the causes a	that I last	saw the	deceased red above.

alive on april ACTUAL SIGNATURE

22b. DATE THEREOF

ADDRESS (Street, city or town, state)

PHYSICIAN'S Dr. Harry Mattax

Camden Ave. Salisbury, 22c NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county)

Maryland

220 BURIAL CREMATION. REMOVAL (Specify) BUTIAL Apr. 20, 1959 Parsons Cemetery 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS

Salisbury, Maryland

24b. REGISTRAR'S SIGNATURE 240. REC'D BY REGISTRAR HOLLOWAY & COMPANY SALISBURY MARYLAND DATE APR 2 0 '59 Cirthury S. Frank



with director,

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certificate

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death certificate



(State)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DATE

Year

19 KG

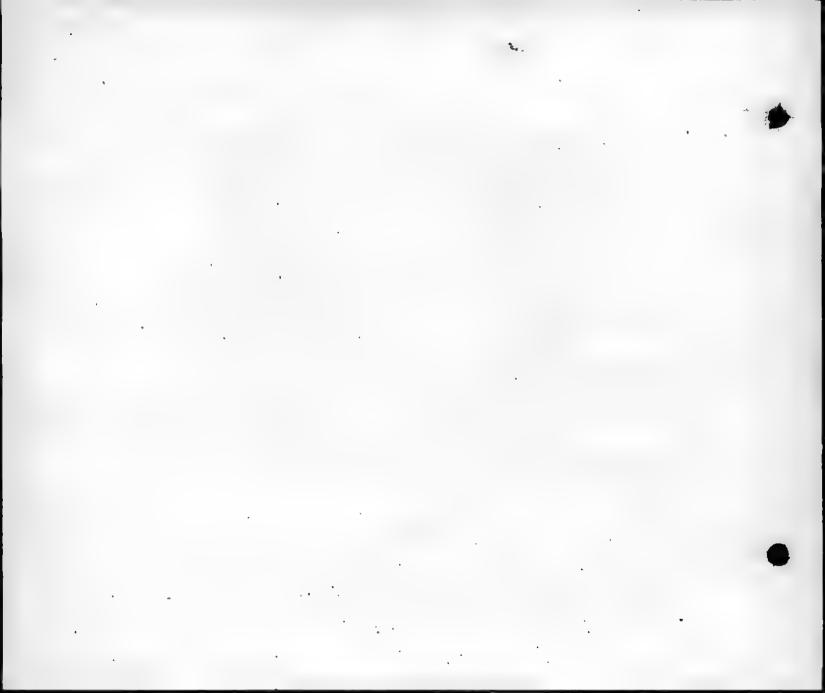
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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



CERTIFICATE OF DEATH

04916 Pag Dist No.

CERTIFICATE OF DEATH Reg. Dist. No.												
1. PLACE OF DEATH COUNTY Wicomico Waryland 2. USUAL RESIDENCE (Where deceased lived. If institution Residen o. STATE Maryland Chai										sion)		
							od Charles side corporate limits, write RURAL and give nearest town)					
Salisi	e nearest lown)		1812 day	d	Hurhes			-				
d. NAME OF HOS	SPITAL (If not in hospital.	give street i	oddress)	0	d. STREET ADDRESS	<u> </u>		آم به ص	1		SIDENCE	
OR INSTITUTIO	Mead State	Hospi	f.e.T								A FARM?	
3 NAME OF		rst	Middle		Lost	4 DATE	Me	onth	De		Year	
[Type or print]	Rich	ard			Goodrich	OF DEAT			12	•	19 59	
5. SEX	6. COLOR OR RACE	7 MARR	IED NEVER MARRIE	D DX	B. DATE OF BIRTH	1	9. AGE (In year lost birthday)				ER 24 HRS	
Male	White	WIDOWS			1866	(?)	lost birthday)		Doys	Hours	Min	
100. USUAL OCCUPA	TION (Give kind of work	done 10b	KIND OF BUSINESS O	RINDU	STRY 11. BIRTHPLACE (SH	ole or foreign	country)	12 C	ITIZEN C	JE WHAT	COUNTRY	
	abor	2}	Farm		Maryl				uS/	Δ		
13. FATHER'S NAME					14 MOTHER'S MAIDEN				0.01	_		
John	n Goodrich				Martha	Sharp	e (?)					
IS. WAS DECEASED E [Yes. no. or unknown] Unk	VER IN U. S. ARMED FO	RCES? 16.	SOCIAL SECURITY NO.	. 17 1	NFORMANT Hospi	tal Re	cords Ad	dress				
18. CAUSE OF E	DEATH Enter only one c	ouse per lin	ne for (o), (b), and (c).]					INT	ERVAL BE	ETWEEN	
PART I C	DEATH WAS CAUSED BY-	, A	rterioscle	roti	ic cardiovas	cular d	disease		ON	SET AND Lears	DEATH	
1422	DUE TO											
Conditions, if		A	rterioscle	rosi	is, general					#		
gave rise to couse (a), statis	immediate (•										
lying couse lo		r)										
PANT II C	OTHER SIGNIFICANT CON Carcin	oma o	CONTRIBUTING TO DEA	ATH BUT	NOT RELATED TO THE TER	RMINAL DISEA	ASE CONDITION G	IVEN IN PA	RT 1(o) 1	PERFO	AUTOPSY DRMED?	
	WAS UNDERLYING D NG D CAUSE OF DEATH IFY MEDICAL EXAMINER]	20b. DESC	CRIBE HOW INJURY OF	CCURRE	D. (Enler noture of injury i	in Part I or Pa	ort II of item 18)					
20c. TIME OF INJ	10	While	Not while		ACE OF INJURY (Home, for ctory, street, office bldg., o		ily or town)		(County)		(State)	
21. I certify	that Lattended the	decease	ed from April	26	19.5/1 , to	April	12 1059	that I	last s	au tha	deceme	
alive on	April 12.	19.5	9 and that	death	accurred at 11:	IOBA Fro	and the course		trial at	dw me	decease	
			, and mar	açum	decorred delegan	ADDRESS (Street, city or town	ana an	me ag	ire state	ea abave Ate signe	
ACTUAL SIGNATURE	G. Alexander	rear	AL.		un Deerts		State Hos		1		3/59	
PHYSICIAN'S NAME (Type)	G. Kosmah	ly, M	.D.				aryland	DI VOL			dadel	
	TION, 22b. DATE THERE	OF .	22c. NAME OF CEME	TERY O			ATION (City, town,	Or countyl		(Stat	(e)	
REMOVAL (Speci	⁽⁵⁾ 4/15/	50	Oldfie		-		ghesvil			(arth	-,	
23. FUNERAL DIRECTO		, .,	ADDRESS	1.(1	24a. RE	C.D BA KEEL	STRAR 24b. REG	ISTRAR'S S	IGNATU	RE		
P.B. F	Robinson -	Leo	nardtown	Ma	DATE	APR 1 6	'59 C	thing 2				

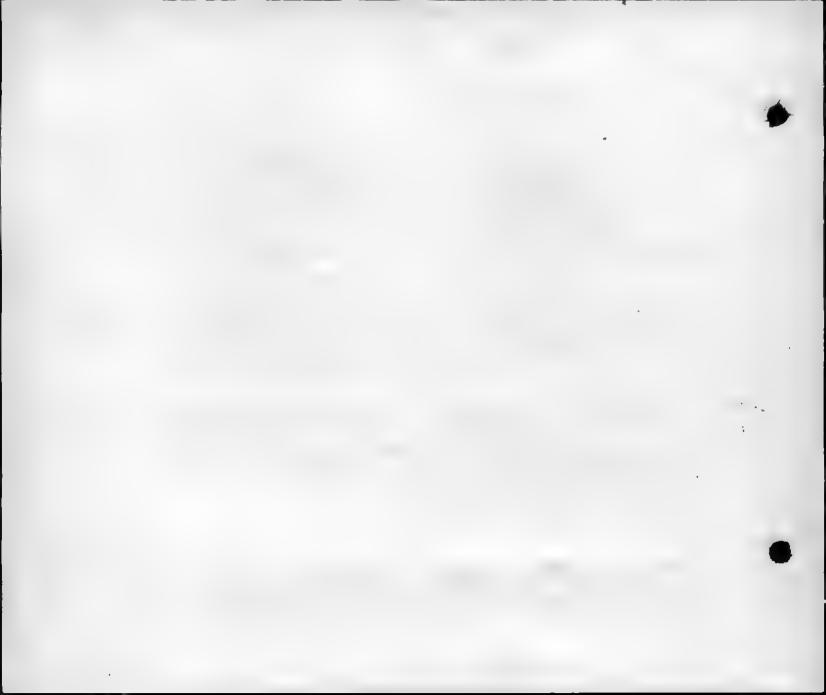
tal director, be filed with TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the hospital ar attending physician and physician and completely filled in by the sail director, the hospital ar allending physician.

After this certificate has been signed by the attending physician and campletely filled in by the facted far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 showing cremation, ar removal, and in any event within 72 hours after death. page 3 should be derached for use as the burnal-tr the registrar prior to burial, cremation, ar removal

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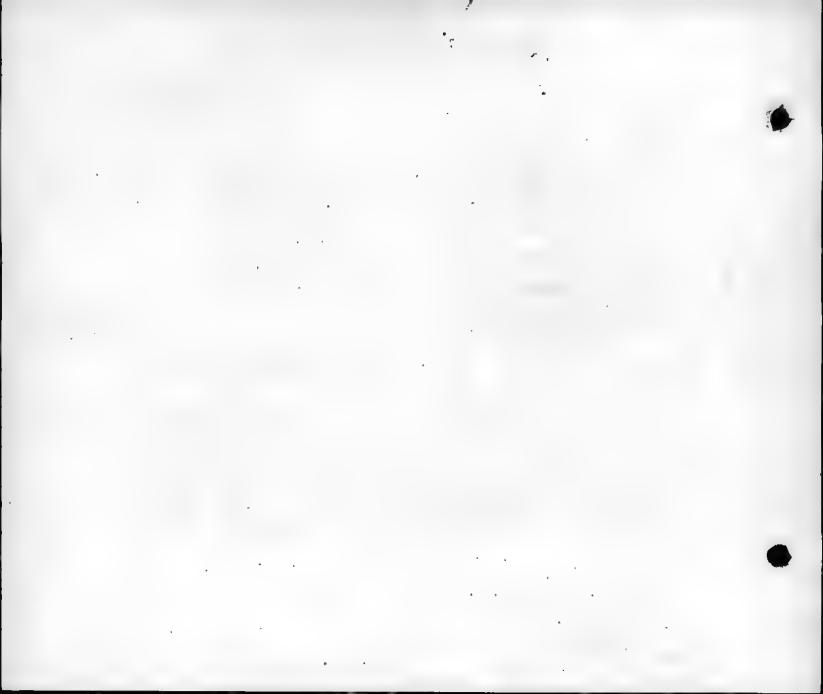
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	1	/	1	MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
	1/2	3		Item 17, Film G242, 5/6/59 fcy CERTIFICATE OF DEATH Reg. Dist. No.
4	o i			Reg. Dist. No. PLACE OF DEATH . 2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission)
Pag	ed e	ķ ,	ľ	O. COUNTY WICE D'MILE MARYLAND STATE MERCH LAND WORCES TO C
÷.	ID 8	1	F	b. CITY OR TOWN (If autside carparate limits, write c. LENGTH OF STAY IN 1b c CITY OR TOWN (If gaffide carparate limits, write RURAL and give nearest town)
	- P			Salar Spirit
Q.	shot	0	٦	d. NAME OF HOSPITAL (If not in happital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
S Inc	9 2	180	4	eninsula General VES NO
A ho	P C		3	NAME OF First Middle Lost 4. DATE Month Day Year OF CO. DECEASED
in 2	oges			(Type or print) CALVII D. DEATH (FX) 2 3 19 3 SEX 16. COLOR OR RACE 7. MARRIED 57 NEVER MARRIED 18 DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HE
W.	. Po	7	1	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8 DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HE 10st birthday) Months Days Hours Min 7. yrs
oted	pers pers	1	小	In USUA, OCCUPATION Give kind of work does 10h KIND OF BUSINESS OF INDUSTRY 12 REPTHEIATE (State or foreign country)
S X G	d col			during nest of working life, even if retired) Own form Delaware USA
be	urbo After		1	3. FATHER'S NAME 14 MOTHER'S MAIDEN NAME
a co	sicio /e cc			Charles F. Gumm Theresa Townsend
ırtifi	phy phy hou		1	Address WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT MATY For. no. or unknown) If yes, give wer or dottes of service) 214-36-5115 P.S. T. O. T
Å.	Jing se r		F	The state of the s
0	pleo vithi		1	PART I. DEATH WAS CAUSED BY: On SET AND DEATH PART I. DEATH WAS CAUSED BY: ON SET AND DEATH
÷	he d hen ent,			IMMEDIATE CAUSE (a) SO PETER TO THE TOTAL TO THE REPORT OF THE PETER TO THE REPORT OF THE PETER TO THE PETER
that	by the			Conditions, if any, which) I cute My our dial Interview
i e	er mi		1	gave rise to immediate OUTTO
260	sit p		1	lying cause last. (c) Color ary acting District
WD	Iran Iran			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPS PERFORMED?
The L	Post Hoiri	ul.		
z	e de la companya de l		20410	20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) (OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
CIA	Tific S # K			
HYS	a Se ce		1	120c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, 120f. (City or lawn) (County) (State of County) 20e PLACE OF INJURY (Home, farm, 120f. (City or lawn) (County) (State of County) 20e PLACE OF INJURY (Home, farm, 120f. (City or lawn) (County) (State of County) 20e PLACE OF INJURY (Home, farm, 120f. (City or lawn) (County) (State of County) (State of County) 20e PLACE OF INJURY (Home, farm, 120f. (City or lawn) (County) (State of County) (Sta
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TE	e tac			alive an
A 4	P P P			SIGNATURE STROMES C. Het J. M.O. Jule 13/4/ Keral 4/28/5
O I	Uld be		/	PHYSICIAN'S
PITA	ERAL 3 shou			NAME (Type)
HOSI	Se S		2	REMOVAL (Specify) 22b DATE THEREOF 22c NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, fown, or county) 4/30/50 11chia 21 22d LOCATION (City, fown, or county) Prontford Del.
0	5 8 E		2	FUNERAL DIRECTOR'S SIGNATURE ADDRESS
	15 (4)			the state of the s
12W	9/58		L	The second section of the second of the seco



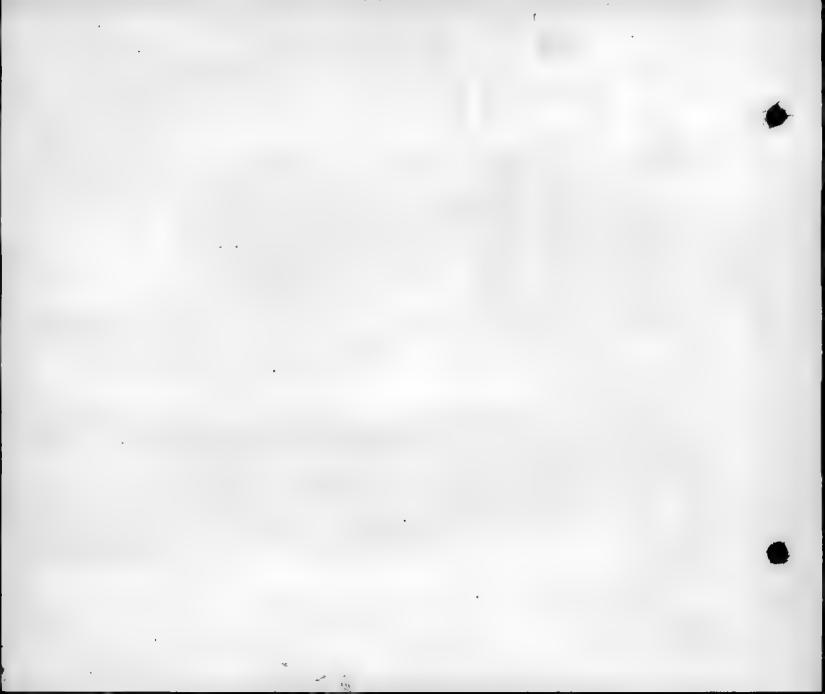


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

()4919 Reg. Dist. No.

	4928		CERT	IFIC.	ATI	E OF DEATH	1			Reg. D	() 날 Pist, No	JI	7
1. PLACE OF DEATH o. COUNTY Wi	comico		MAR	YLAND	2.	USUAL RESIDENCE (Who state Maryla		ed lived b.	If institution	on Reside	ence before	re odmi	e¹s
b. CITY OR TOWN (I RURAL and give no	f outside corporale fire	ils, write	c. LENGTH OF STA	Y IN 1b		CITY OR TOWN (If o	ulside carp						
Salisbur	y		7½ yrs			Bladensb	ourg		i		ai		
OR INSTITUTION	AL (If not in haspital,					d STREET ADDRESS						e IS RE	SIDENCE A FARM?
Deer's H	ead State	Hospi	tal			49 Upshur	Stre	et] NO []
3. NAME OF DECEASED (Type or print)	Ro	se 50	Middl			Henson	4. DATE OF DEAT		Apr		2	iy	Year 19 59
S. SEX	6. COLOR OR RACE	7 MARE	HED NEVER MARE	RIED 📆	B. Da	ATE OF BIRTH	-	9 AGE	(In years				ER 24 HRS
Female	Colored	WIDOW	ED DIVORC	ED 🔲		? 1	897		irthday) 2 yrs	Months	Days	Hours	Min
100. USUAL OCCUPATIO	ON (Give kind of work ling life, even if retire	dane 10b.	KIND OF BUSINESS	OR INDU	STRY	11 BIRTHPLACE (Stole	or fareign	country)		12 C	ITIZEN C	F WHA	COUNTRY
Maid	ang mo, crew a reme		Housework			Washingto	n, D	.C.			USA	1	
13. FATHER'S NAME					14	MOTHER'S MAIDEN N							
Lloyd He	nson					Laura Ca	zer						
15. WAS DECEASED EVE	R IN U. S. ARMED FO III yes, give wor or dates of	RCES? 16.	SOCIAL SECURITY N	0. 17, 1	NFOR	MANY Hospit	al R	ecord	S Add	ress			
1B. CAUSE OF DEA	TH [Enter only one c	ouse per li	ne far (a), (b), and (c	1.]							İINT	ERVAL B	ETWEEN
PART I. DEA	TH WAS CAUSED BY	. (Coronary t	hrom	bos	is					QN!	MI ANI	utes
420.1 DUE TO													
Conditions. if ony, which) Arteriosclerotic cardiovascular disease								?					
gove rise to immediate cause (a), stating the under-							_						
lying couse lost.	ine <u>under-</u>	2)											
PART SI OTH	ER SIGNIFICANT CON	IDITIONS (ONTRIBUTING TO D	EATH BUT	TON	RELATED TO THE TERMIN	NAL DISEA	SE CONDI	TION GIV	EN IN PA	RT 1(a) 1	9 WAS	AUTOPSY
	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES NO IN NO.												
200. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJURY	OCCURRE	D (Er	iter nature of injury in P	art I or Po	ort II of ite	m 18 }	<u> </u>			
20c. TIME OF INJUR	Y Manth, Day, Ye	ar 20d. II While	Not while	20e. PL fo	ACE (OF INJURY (Home, farm, street, affice bldg., etc.	20f. (Ci	ly ar tawn))		(County)		(Slate)
				t. 30	7	, 1951 to A	man I	2	Ę.				
	of I offended the					. 1924 , to	D TE		1927	_,that	lost so	w the	decease
alive onAp	KILL Z	, 12.5	\mathbf{Z}_{-r} , and the	t death) acc	curred of 16342	奶, fro	m the c	auses a	nd on	the do	te stat	ed obove
ACTUAL SIGNATURE	or. blue	rui	an		M.D.	Deer's H		State		,	. 1	1/2/	ATE SIGNEL
PHYSICIAN'S NAME (Type)	V. Juerman	. M.	D			Salisbur	у, М	aryla	nd				
220 BURIAL CREMATIO REMOVAL (Specify)	N, 226. DATE THEREO	"9 L	Valu	el W	اعا	2- Salura	22d 10C	OH I	y town o	county)	Use	(510	le)
23. FUNERAL DIRECTOR'	SIGNATURE		ADBRESS			24a REC'D	BY REGIS	TRAR 2	4b REGIS	TRAR'S S	IGNATU		
						DATE AP	R 1 0'	59	Q.	ILua f	de de		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4929 CERTIFICATE OF DEATH with I director, filed with PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY a. STATE Maryland Wicomico **b** COUNTY MARYLAND Queen Anne's 6 b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give negres) town) RURAL and give negrest town) Ingleside 20 days Salisbury d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS Deer's Head State Hospital None ON A FARM? 25 YES I NO TO 2 NAME OF Middle Lost 4. DATE Month Year DECEASED 1959 Medford Holden April (Type or print) DEATH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years FUNDER 1 YEAR IF UNDER 24 HRS last birthday) Months Dovs 11/25/1890 Male White WIDOWED IX DIVORCED | papers. ᇻ 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

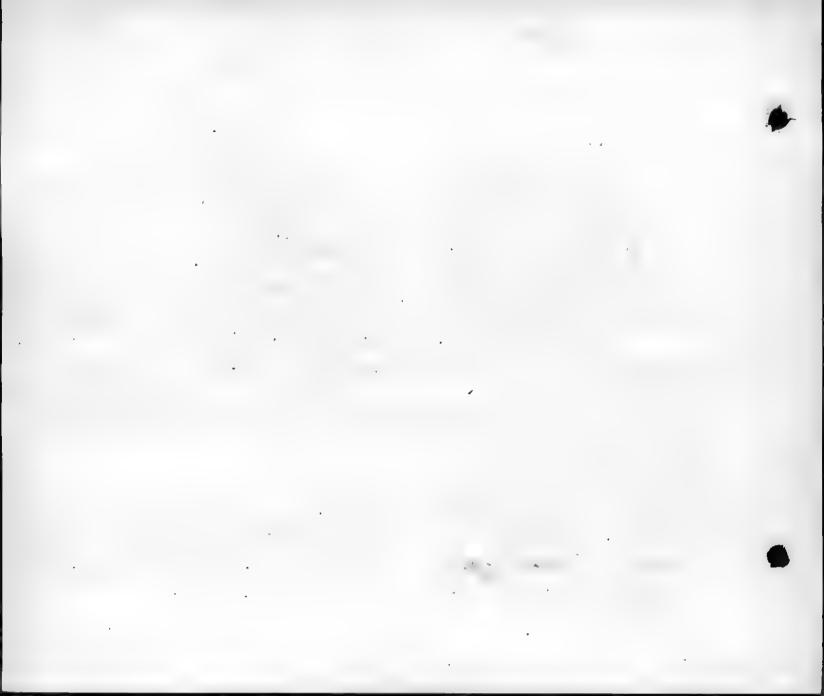
10b. KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country) COM 12. CITIZEN OF WHAT COUNTRY? USA Marvland puo Tennant carbon 3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME after physician William Holden Record mave 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT Records Hospital ottending 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I, DEATH WAS CAUSED BY: Cerebral thrombosis with rt. hemiplegia and weeks motor aphasia DUE TO þ Hypertensive cardiovascular disease Years permit. Conditions, if any, which ! gned gove rise to immediate **DUE TO** cause (o), stoting the underhos been si lying couse lost. burial-tronsit attending physician PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THETERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? YES 🗍 NO 💢 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b, DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.) certificate WEDICAL 20c. TIME OF INJURY 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f. (City or town) Doy. Year (County) (Stole) foctory, street, office bldg., etc.) a. m. While Not while at work of work April April 22 1959 that I last saw the deceased 21. I certify that I attended the deceased fram, and that death accurred at 7:45P M, from the causes and an the date stated above. April DATE SIGNED ADDRESS (Street, city or town, stote) ACTUAL SIGNATURE Deer's Head State Hospital prior TO FUNERAL DIRI PHYSICIAN'S G. Kosmahly, M.D. registrar Salisbury, Maryland NAME (Type) 22b. DATE THEREOF 220. BURIAL, CREMATION, 22c NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (Stole) Busic FUNERALDIRECTOR'S SIGNATURE **ADDRESS** 24g. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATAPR 2 7 '59 VS A1S (4) arthur I Hay 1SM 9/SB

executed

pe

certificate

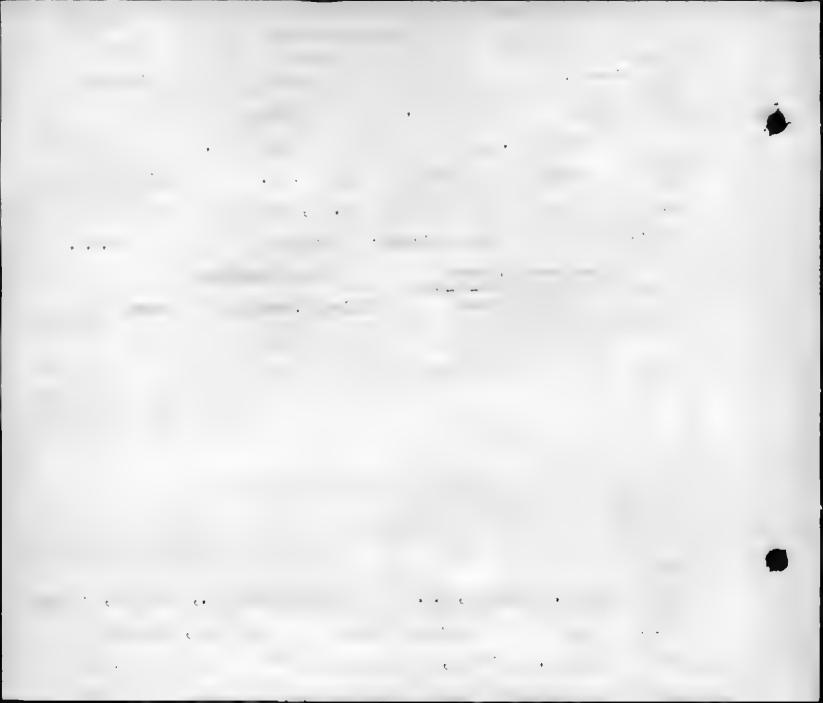
requires that the death



deoth.



1	П	MAKTLANU STATE DEP	AKIMENI OF	HEALIH-BALIM	ORE, 18 04922
_	ı	4937 CER	TIFICATE OF	DEATH	Reg. Dist. No.
director,	1	PLACE OF DEATH	myraam o. STATE		If institution: Residence before admission) COUNTY
le l		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fown) Selisbury 7 yr	AY IN 16 c. CITY O		nits, write RURAL and give nearest town)
PA SA		d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION Eastern		Fastern Ave	e. IS RESIDENCE ON A FARM? YES NO
illed in bes I and	3	NAME OF First Mid DECEASED (Type or print) CHARLES EDWAR		LOST 4. DATE OF ISON SIR DEATH	Month Day Year April 8 1959
rs. Pag	5	SEX 6. COLOR OR RACE 7. MARRIED NEVER MAI White Widowed I	RRIED 8 DATE OF BI	RTH 9. AG	E (In years birthday) Months Days Hours Min
nd camp on pape death.	L	On USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Funeral Di	or industry 11. Birth	IPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
physician an move carbon höurs after o	1:	o father's NAME William Leenard Johnson		r's maiden name Emily Rickardso	
	Ti Ti	S. WAS DECEASEDEVER IN U. S. ARMED FORCES? Yes no. or unknown [If yes, give wor or dotes of service] ***********************************	20. 17. INFORMANT	B .Johnson	Address
ne attending hen please r		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		rliage	INTERVAL BETWEEN ONSE AND DEATH
aned by the		Canditions, if any, which gave rise to immediate cause (a), stating the under-	Elecosis	,	Tyro.
hysician. been signal. I-transit val, and	Z	lying cause lost. (c)	DEATH BUT NOT RELATED	TO THE TERMINAL DISEASE CON	PERFORMED?
ending plicate has icate has buria	CERTIFICATION	200. ACCIDENT WAS UNDERLYING [] OR. CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	OCCURRED (Enter nature	af injury in Part I or Part II of i	YES NO
his certif	MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While Not while of work of work	20e PLACE OF INJURY foctory, street, off	Y (Home, form, 20f. (City or town fice bldg., etc.)	(County) (State)
he haspite R: After I ached for buriol, cre		21. I certify that Lattended the deceased from	16 . Toly at death accurred a	1., to 7/8	, 1917 , that I last saw the deceased causes and an the date stated above
or to		ACTUAL COLUMN FELLICATION	M.D	ADDRESS (Street, ci	
RAL DIR should b istrar pris		PHYSICIAN'S NAME (Type) Earl M. B cardsley, M.D.		07 Maryland Ave	. Salisbury, Maryland
TO FUNERAL page 3 shoul the registrar		BURIAL 4/11/1959 Parsons	METERY OR CREMATORY Cometery	22d LOCATION (C	city, lawn, or county) (State)
VS A15 (4) 15M 9/55	23	Hill & Johnson Co. Salisbury, Ma	iryland	240. REC'D BY REGISTRAR DATE APR 1 3 '59	246 REGISTRAR'S SIGNATURE CARTING & House
		Burge C. Nie E			





VS A15 (4) 15M 9/58

MARYLAN	ID STA	TE DEPAR	TMENT C	OF HEALTH-	BALTIMORE.	18
1	tems	11, 10	12 GZ4	2 5-13-19	-BALTIMORE,	

4933 CERTIFICATE OF DEATH

Reg. Dist. No.

04924

1 PLACE OF DEATH O. COUNTY MARYLAND	2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b	c CITY OR TOWN (If outside corporate limits, write RURA) and give nearest town)
RURAL and give nearest town)	Halisteny Md
d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION	d. STREET ADDRESS e. 15 RESIDENCE
PENINGULA GENERAL HOSPITAL	ON A FARM? YES NO []
3. NAME OF DECEASED (Type or print)	KING DATE Month Day Year OF BEATH APRIL 75 1957
S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED	B. DATE OF BIRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HIS.
FEMALE COLORED WIDOWED DIVORDED	1986 Jost Jithday) Months Days Hours Min.
10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDU	STRY 11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY?
Domistic none	Princess Anne. Md. U.S.A.
13 FATHER'S NAME	14 MOTHER'S MAIDEN NAME
John Curlis	orangette Jell Clark
15 W/S DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, no of unknown) (If yes, give war ar dates of service)	IN ORMANT Address
none	fendly Utua
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: 14 MOCKINGER	Escapticone Della
DUE TO / //	· /// / / Makagan
Conditions, if any, which) by Atthenseuse	me Herry alexense
gove rise to immediate DUE TO	
lying couse lost. (c)	
FAMILIOTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED?
(IF EITHER, NOTIFY MEDICAL EXAMINER)	Enter noture of injury in Sart I or Port II of Item 18)
	ACE OF INJURY (Home, farm, 20f. (City or town) (Caunty) (State)
Hour o. m. p. m. 19 While Not while of wark of wark	ctory, streel, office bldg., etc.)
21. I certify that attended the deceased from I And	1907, to Wine 25, 195 That I last saw the deceased
alive on April 215 /19 55, and that death	occurred of 5 10M, from the causes and on the date stated above.
Mr. C. K. H.	ADDRESS (Street, city of town, stote) DATE SUSNED
SIGNATURE Mind / Jelier	MO. Allestor Del 7/27/59
PHYSICIAN'S	
NAME (Type)	
220 ANRIAL, CREMAT ON, 226. DATE THEREOF TRAME OF CEMETERY OF CEME	OR CREMATORY 22d COCATION (City, town, or county) (Stote)
23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24g. REC'D BY REGISTRAR 24b REGISTRAR'S SIGNATURE
1 goaler Muss	DATE MAY 5 '59 arthur & trans



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 4934

CERTIFICATE OF DEATH

0492;

Rea, Dist. No.

	V
W	- 1
	Я

1. PLACE OF DEATH a. COUNTY

Wicomico MARYLAND

Maryland

2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) **b** COUNTY Wicomico

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

b. CITY OR TOWN (If outside corporate limits, write c LENGTH OF STAY IN 1b RURAL and give negrest town)

	h.	PERTISORI J		10		prutj				
	d. NAME OF HOSPIT. OR INSTITUTION	AL (If not in hospital, give : 504 South F	Park Drive	, STREET		South	Park	Drive	e. IS RESID ON A F YES	ARM?
	NAME OF DECEASED (Type or print)	LOUIS	Middle HENRY	KRAU	S SR	4. DATE OF DEATH	APRI	L 5th		59
5. 5	Male	J. 1.11 . A A	MARRIED X NEVER MARRIED DIVORCED DIVORCED	B. DATE OF BIR			AGE (In year lost birthdoy	. I S. C	Hours	24 HRS Min
	or of Pha	ing life, even if retired)	106. KIND OF BUSINESS OR INDU Pharmacis				_{mtv)} y Mary		OF WHAT O	
F	father's NAME Herman M.		•		ise E	lizab	eth Th			
IYg		R IN U. S. ARMED FORCES?	16 SOCIAL SECURITY NO U7	informant uls H.I Salisbi	(raus	(Son)	431 V	irginia	Ave	•
		TH WAS CAUSED BY IMMEDIATE CAUSE (0) DUE TO Ty, which (b)	per line for (o). (b). and (c).	Elw	rioi	?			SET AND C	
CATION	Couse (o), stoting to lying couse lost. PART II OTH) (c)	DNS CONTRIBUTING TO DEATH BU	T NOT RELATED T	O THE TERMI	NAL DIŞEASE	CONDITION	GIVEN IN PART 1(0)	PERFOR	UTOPSY MED? NO (X)
E.	20- ACCIDENT MA	C LIA INCRUMENTA TO DOM	OFFICEING LIGHT WILLIAM A COLUMN	10						

20g ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year

20d. INJURY OCCURRED While Not while at work at work

20e. PLACE OF INJURY (Home, form, 20f. (City or town) foctory, street, office blog., etc.)

(County) (Stole)

21. I certify that bottended the deceased from olive on

and that death occurred of 2:30A

......, 19____,that I lost saw the deceosed M, from the couses and on the date stated above

ACTUAL SIGNATURE

Apr.8,1959

DATE SIGNED

Dr. Fred R. Gramse 220. BURIAL, CREMATION, 226 DATE THEREOF

HOLLOWAY & COMPANY

402 S. Division St. Salisbury, Md. 22c NAME OF CEMETERY OR CREMATORY

22d LOCATION (City, town, or county) Wicomico Memorial Park

ADDRESS (Street, city or town, state)

Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

SALISBURY MARYLAND

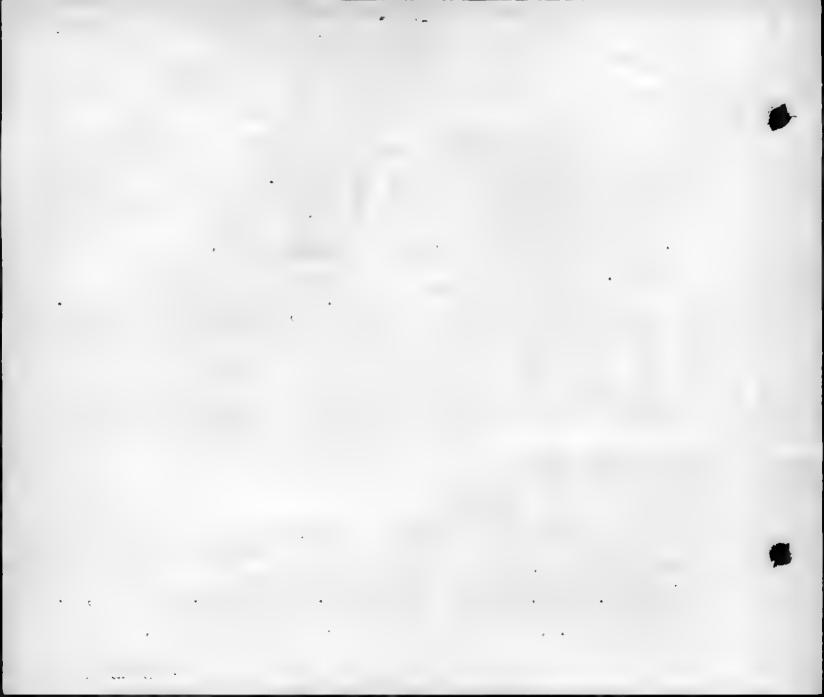
24g REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE Orthur & House

TO FUNERAL DIRE VS A15 (4) 15M 10/57

■HYSiCIAM: The lam requires that the death contificate

Surial-transit



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



VII A15 (4) 15M 9/5B

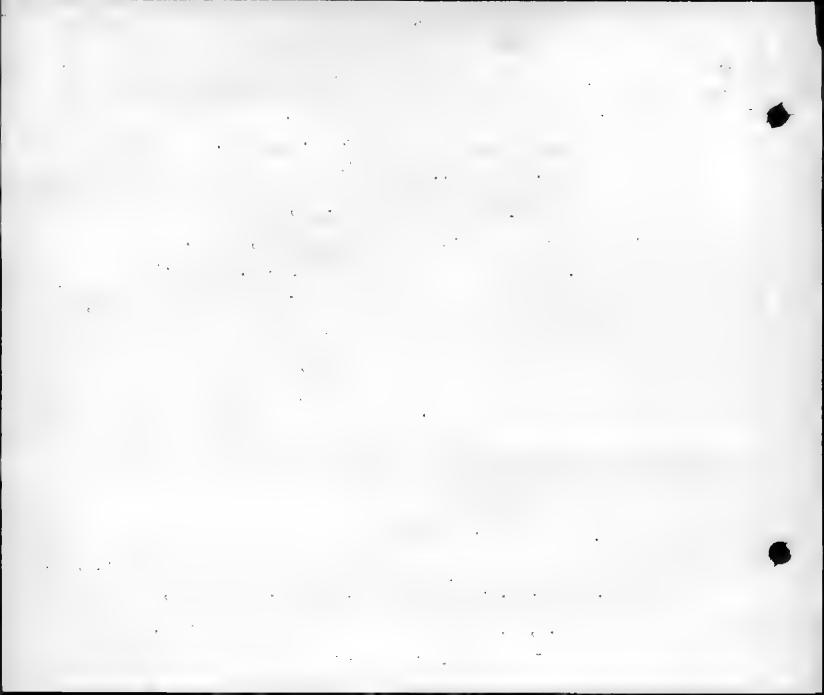
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4936

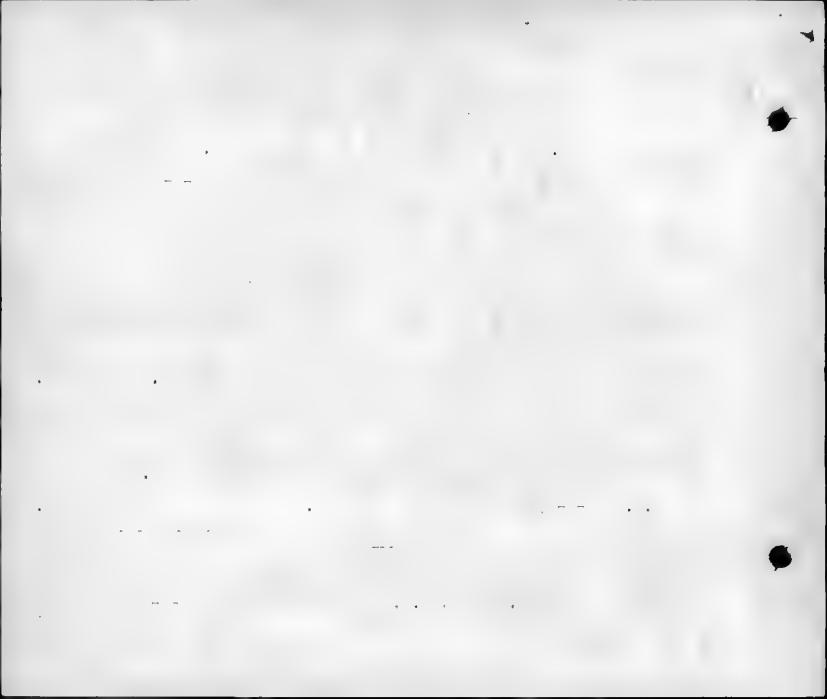
CERTIFICATE OF DEATH

Reg. Dist. No. 27

V	1, PLACE OF DEATH 0, COUNTY.	2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
Ż	WIED MARYLAND	· STATE JAMA & b. COUNTY / COm (60
	b. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lawn)
	Sahisbury	Jakistruity 1d
1	d. NAME OF HOSPITAL (If pot in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS o. IS RESIDENCE ON A FARM?
	Peninocha deneral	103 RIVER- SIDE DIIVE YES NO
	3 NAME OF First Middle DECEASED DECEASED	Last 4. DATE Month Day Year
	(Type or print) BENJAMIN T.	ACCOX DEATH Upril 5 1957
	5. SEX 6. COLOR OR RACE 7 MARRIED NEVER MARRIED	B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 154 birthday) Manths Days Hours Min.
	Male White WIDOWED M DIVORCED	Nov. 27, 1876 By birthday) Manths Days Hours Min.
	10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR INDU during most of working life, even if retired)	STRY 11 BIRTHPLACE (State or foreign country) 12.CITIZEN OF WHAT COUNTRY
1	Laborer- Lumber Mill Mill Work	Salisbury, Maryland USA
	13. FATHER'S NAME	14 MOTHER'S MAIDEN NAME
	William B. Maddox	Virginia B. McCallister
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yest, no. or worknown) (If yest, give wor or dates of service)	Normanty L. Hitchens (Brother-In-Law)
	(Yes, no, oc.upknown) (If yes, give wor or dates of service)	'03 Riverside Road Salisbury, Md'
	1B. CAUSE OF DEATH [Enter only one cause per line fop (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
	PART I. DEATH WAS CAUSED BY: Ven Vicules T	Willalia Juila
	420.1 DUE TO	0 / /
	Condition is now which I have been added.	1 Inforche 12 hrs
	gove rise to immediate	7
	lying cause lost.	in Disease 2-34/10
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT 200 ACC DENT WAS UNDERLYING TO 200. DESCRIBE HOW INJURY OCCURRE OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	PERFORMED?
	206. ACC DENT WAS UNDERLYING 206. DESCRIBE HOW INJURY OCCURRED OR CONTRIBUTING CAUSE OF DEATH	D (Enter nature of injury in Part I ar Part II of item 18)
	Hour o. m. While Not while for	ACE OF INJURY (Hame, farm 20f. (City or town) (Caunty) (State ctary, street, affice bldg , etc.)
	₹ p. m. 19 at work at work at work	
	21. I certify that I ottended the deceased from	1953, to while I last saw the deceased
	olive on and 5, 1955, and that death	occurred of 10 33M, from the couses and on the dote stoted above
	0/- 1	ADDRESS (Street, city or town, state) DATE SIGNED
/	SIGNATURE TO Ellean Dyna	M.D. Apr. 6/1959
0	PHYSICIAN'S Dr. William D. Gray	Camden Ave. Salisbury, Maryland
	220. BURIAL CREMATION, 22b. DATE THEREOF 22c NAME OF CEMETERY CREMOVAL (Specify Apr. 9.1959 ParsonsCen	
	23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS LIOT TO LIAY 9 GONTO ANY CAT TO DIVIDE MATERIAL PROPERTY.	24d. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE
	HOLLOWAY & COMPANY SALISBURY MAR	RYLAND DAAPR 9 '59 arching & thous



1			ENT OF HEALTH—BALTIMORE, 18	04090
STATE		MEDICAL EXAMINER	'S CERTIFICATE OF DEATH	()4928 g. Dist. No.
H DEPT.	1. P	ACE OF DEATH COUNTY Wicomico MARYLANG	2. USUAL RESIDENCE (Where deceased lived it institution o. STATE Maryland b. COUNTY W	Residence before odmission) icomico
	b.	CITY OR TOWN In outside corporale hmits, write BURAL ond give negresi lown)	c. CITY OR TOWN (If outside corporate limits, write RURA	
	ď	Salisbury VIIIBMAK NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)	Salisbury d. STREET ADDRESS	e IS RESIDENCE
<u>.</u>		521 Race St.	521 Race St.	YESNO [
5	C	AME OF First Middle CFASED / Middle Frances]	Marshall death 4-7-	19 59
5	5. \$	6. COLOR OR RACE 7 MARRIED WEVER MARRIED WIDOWED DIVORCED	8. DATE OF BIRTH Sec. 1-1908 9. AGE (In year) Interpretation by the day Mon	NDER LYEAR IF UNDER 24 Hks lihs Doys Hours Min
	10o.	USUAL OCCUPATION (Give kind of work done 10th KIND OF PUBLICESS OR INDU	STRY 11. BIRTHPLACE (Stote or foreign country)	CITIZEN OF WHAT COUNTR
,	13.	ATHER'S NAME TO A STATE OF THE	14. AOTHER'S MAIDEN NAME	
$\langle I \rangle$	15		INFORMANT DESIGNATIONS	000
	[Yes,	110 110ne XII	n Oswald Stardy Have	De Grace Mi
and		B. CAUSE OF DEATH [Enter only one course per life for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) ASPHYX1a.		INTERVAL NETWORN ONSET AND PLATH Suddon
yol,		7/6.0 DUE TO		- Director
		Conditions, if any, which gove rise to immediate cause (a), stating the underlying DUE TO	urns 100 % body surface.	_Sudden.
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BU		10107
	CATION			PERFORMED?
	ERTIF	PRIMARY-19 or CONTRIBUTING	(Enter noture of injury in Fart Lor Port II of item 18) and bed and house burned.	
	MEDICAL (20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. P	LACE OF INJURY (Home, farm. 20% (City or town) pctory, street, office bidg., etc.)	(County) (5'ote)
d,	MED	1 A. M. 4-7-59° of work of work X	wn Home. Salisbury Wi	
		21. I certify that I taok charge of the remains described at opinion death resulted from: Natural causes . Accident		
		opinion death resolved rain: National Cooses, Accident	21. Joidide , Homicide , Onderermin	DATE SIGNED
		ACTUAL SIGNATURE CONT.	M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER	DATE SIGNED
D 35		Examiner's Harl L. Royer, M.D.	DEPUTY MEDICAL EXAMINER 1 1-9-5	59
	70	BYRIAL, CREMATION 27b. DATE THEREOF 2 NAME OF CEMETERY OF MOVAL (508-15)	OR CREMATORY 1 224 LOCATION (City, 1941), or con	unty) (Stote)
* 7	23.	STREET DIRECTOR'S SIGNATURE ! ADDRESS !	APR 1 3 '59 CIVAL CAN REGISTRAL	ES SIGNATURE
2		reggo gimme snowikle	MIG DATE	



CERTIFICATE OF DEATH 4938 Rea. Dist. No. directar, PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) Filed e. COUNTY b. COUNTY Wicomico Maryland Wicomico MARYLAND ard. b CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) pe Salisbury Hebron d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION d. STREET ADDRESS . IS RESIDENCE ON A FARM? Railroad 200 Deer's Head State Hospital YES TO NO TO 2. NAME OF Middle 4. DATE Month Day Year Afilled 1 DECEASED April Race Marvel 59 Raymond (Type or print) DEATH 19 6 COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS (ost birthdoy) 9/2/1894 Months Dovs White Male WIDOWED [7] DIVORCED | yrs. apers 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) USA Marvland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Clara Belle Beach James Franklin Marvel physicio Mrs. Mary Marvel (wife) Hailroad St 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. Yes thending Hebron, Maryland 1B. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH 굽 PART I. DEATH WAS CAUSED BY: Esophageal varicose veins - bleeding 7 IMMEDIATE CAUSE (o) **DUE TO** Myocardial insufficiency Conditions, if ony, which permi signed gove rise to immediate **DUE TO** couse (o), stoting the underbur al-transit processit p lying couse lost attending physician has been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? Rheumatoid arthritis, multiple; diabetes YES NO X 20g. ACCIDENT WAS UNDERLYING DOR CONTRIBUTING DO CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) certificate (IF EITHER, NOTIFY MEDICAL EXAMINER) WEDICAL 20c. TIME OF INJURY Month, Doy. Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) ö factory, street, office bldg., etc.) Hour o. m. Not while of work of work April 23 159, that I last saw the deceased April 21. I certify that I attended the deceased fram, defoched ___, and that death accurred at 11:10A, from the causes and an the date stated above ADDRESS (Street, city or town, stote) DATE SIGNED ACTUAL Deer's Head State Hospital TO FUNERAL DIRECT poge 3 shauld be prior e e Zooner and a SIGNATURE PHYSICIAN'S G. Kosmahly, D. Salisbury, Maryland NAME (Type) 220. BURIAL, CREMATION, 226. DATE THEREOF 22 NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (Stole) Apr. 25, 1959 Sharptown, Maryland Fireman's Cemetery 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24n. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE APR 2 7 '59 VS A15 (4) Ciriling & Harry HOLLOWAY & COMPANY SALISBURY MARYLAND 15M 9/58

be executed within 24 hours

death

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18





1		MARTLAND STATE DEPART	MENT OF HEALTH—BALTIMORE,	
e ose		4940 CERTIFIC	CATE OF DEATH	Reg. Dis 14931
filed with		PLACE OF DEATH C. COUNTY MARYLAN MARYLAN	2. USUAL RESIDENCE (Where deceased lived. If institution on STATE b. COUN Maryland W.	
d be f		b CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town)	b c. CITY OR TOWN (If autside corporate limits, writ	
Should Copy	. 12/	d. NAME OF HOSPITAL (If for in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS	e IS RESIDENCE ON A FARM? YES NO
and and and	3.	NAME OF First Middle	Last 4. DATE	Wanth Day Yeor
othin 24 Figes 1	_	(Type or print) FLORENCE EDNA	MAXWELL DEATH APRI	L 15 1959
i de s	F	6. COLOR OR RACE 7. MARRIED NEVER MARRIED E	May 3.1900 58	y) Manths Days Haurs Min
comp	10c	USUAL OCCUPATION (Give kind of work done during most of working life, even if refired)		12. CITIZEN OF WHAT COUNTRY?
8 9 5 8	13.	House Keeper Own Home	Connecticut	U.S.A.
physician a mave carbo Maurs after	15.	WAS DECEASEDEER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.	Mary Bernard	Address
ing p	L	None	Mrs. Ethel Adkins, Same	
ne dear attendi		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH
es that the day the mit. The any even		(b)	PYRIONEPHRITIS	yean.
require: ian. in signects: nsit pern and in a		gove rise to immediate couse (o), stating the under-tying couse (ost.	LOSIS OF KIDNEY	Year.
le law physicii las beer ial-fran laval, a	CATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH MALIGNANT HYPERT	BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION	GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? YES NO
IAN: TI ending ficate h the bur or rem	CERTIF	206. ACCIDENT WAS UNDERLYING A CONTRIBUTING A CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	IRRED. (Enter nature of injury in Port 1 or Port 11 of item 18)	
PHYSIC il ar att nis certi use as mation,	MED CAL	20c TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e Hour a.m., While Nat while of wark at work at work	PLACE OF INJURY (Hame, farm, 20f. (City or tawn) factory, street, affice bldg , etc.)	(County) (State)
DING a haspita After the ned far 'al, gre		21. I certify that I attended the deceased from Selver	$(4//\epsilon/)$	that I last saw the deceased
detach ta bur		the View	ath accurred and T2/2M, from the causes ADDRESS (Street, city or to	and an the date stated above DATE SIGNED
DIRECTION DIRECTION DIRECTION DE LA PRIORETE		ACTUAL SIGNATURE PARTY	M.D. Salisbury, Maryland	4/15/59
SPITAL O		PHYSICIAN'S NAME (Type) O. J. Burton 213 M	aryland-Ave. Salisbury, Md	* ***********************************
5 8 2 0 0 0	220	BURIAL, CREMATION, 22b. DATE THEREOF 22c NAME OF CEMETER		vn, ar county) (State)
5 5 5 5	23.	FUNERAL DIRECTOR'S SIGNATURE ADDRESS		CONN EGISTRAR'S SIGNATURE CITTURA & TELEVIA
YS A15 (4) 15M 9/5B	L	Hill & Johnson Co. Salisbury, Maryl	and DATE APR 21 '59	Committee 2.
		norman t. Raker		



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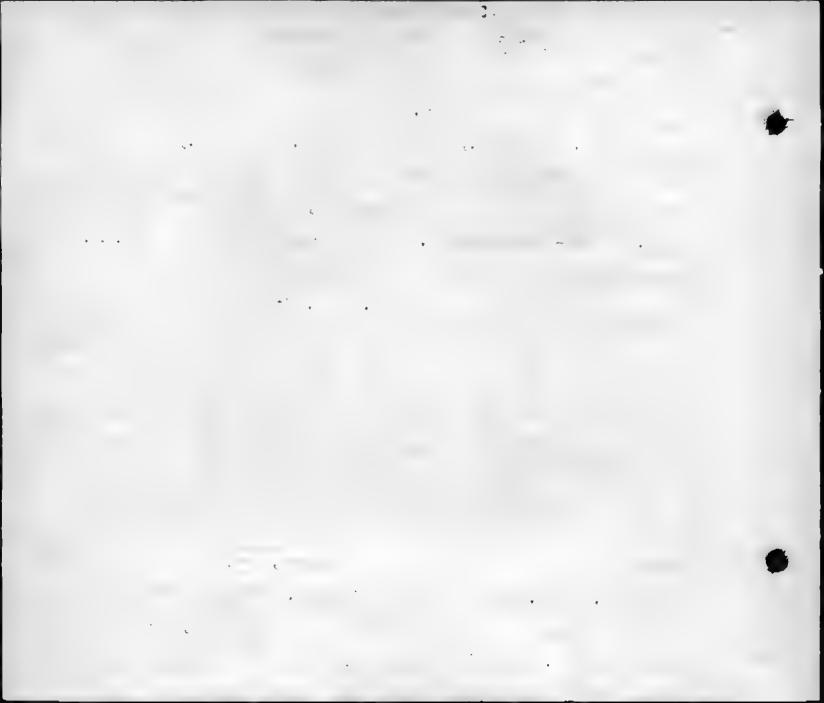
haurs aft

executed within 24

requires that the death certificate

Q

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



death Page 4

*** ITIMINAL PHYSICAN: The law requires that the death certificate be executed within 24 llours offer

04933

	4941	CERTIFICA	ATE OF DEA	ATH		Reg. Dist	. No.	
	icomico	MARYLAND	2. USUAL RESIDENC	E (Where decease yland	d lived. If instituti b COUNTY		imore (
b. CITY OR TOWN (RURAL and give n	If outside corporate limits, write	c. LENGTH OF STAY IN 15	c. CITY OR TOWN	V (If outside corpo	prote limits, write R	URAL ond gi	ve nearest low	m)
Salisbur	У	13 days	Baltin	more	23	. 1.	į	
OR INSTITUTION	TAL (If not in hospital, give street		d. STREET ADDRE	SS				SIDENCE A FARM?
Deer's	Head State Hosp	oital	1309 As	hland Av	enue			NO [
3. NAME OF DECEASED	First	Middle	lost	4. DATE OF	Mon		Day	Yeor
(Type or print)	Vander		Morris	DEATH	Apri	il	6	19 59
i. SEX	6. COLOR OR RACE 7. MAR	RIED NEVER MARRIED	8. DATE OF BIRTH		9. AGE (In years lost birthdoy)		YEAR IF UND	
Male	Colored WIDOW		3/12/08		51 yrs	Months	oys Hours	Min
during most of wor	ON (Give kind of work done 10b. king life, even if retired)	KIND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (Slote or foreign o	country)	12 CITIZ	EN OF WHA	COUNTR
	IBNE	-	Mary.			I	JSA	
B. FATHER'S NAME			14. MOTHER'S MAIL					
Hyman					Morris			
5, WAS DECEASED EVE Yes, no. or unknown[R IN U. S ARMED FORCES? 16.	SOCIAL SECURITY NO. 17. I	NFORMANT HOS	pital Re	cords Add	ress		
18. CAUSE OF DEA	ATH [Enter only one couse per li	ne for (o), (b), and (c).]					INTERVAL B	
PART I DEA	TH WAS CAUSED BY: IMMEDIATE CAUSE (6)	Cor Pulmonale					ONSET AND	DEATH
241X	DUE TO							
Conditions, if o	ny, which) (b)	Bronchial asth	ma				10 y	rs
gove rise to i	mmediate (i	
lying couse lost.	(c)							
	HER SIGNIFICANT CONDITIONS				E CONDITION GIV	EN IN PART	(o) 19. WAS	AUTOPSY ORMED?
Oals X Ne	urosyphilis wit		<u> </u>					NO 🔀
	AS UNDERLYING [] 20b. DES CAUSE OF DEATH MEDICAL EXAMINER)	CRIBE HOW INJURY OCCURRE	D (Enler noture of inju	y in Port I or Por	1 II of item 18)			
20c. TIME OF INJUR Hour o. m.	While	NJURY OCCURRED 20e. FL. Not while	ACE OF INJURY (Home, tory, street, office bldg	form, 20f. (City	or town)	{Co	uniy)	(Stole)
	19 of wor							
21. I certify th	at I attended the deceas				<u>6, 1959</u>	.,that I la	st saw the	decease
alive onAp	ril 6,	2, and that death	accurred at 7.5	15A M, from	n the causes a	ind on the	date stat	ed abov
ACTUAL A	7. Vius nuis			· ·	Ireet, city or town,			ATE SIGNE
SIGNATURE	· · · · · · · · · · · · · · · · · · ·	u,	M.D. Deer':	s Head S	tate Hosp	oital	4/9	6/59
PHYSICIAN'S TO NAME (Type)	Juerman, M. I).	Salis	bury, Ma	ryland			
20. BURIAL, CREMATIO	N, 22b. DATE THEREOF	22c NAME OF CEMETERY O	R CREMATORY	22d LOCA	TION (City, town, o	or county)	(Sto	le)
REMOVAL (Specify)	4-10-57	ROCKAL ALEDIN	Cimetan	Reit	de 4/41.1	1	111	
3. FUNERAL DIRECTOR	S SIGNATURE	ADDRESS	240.	REC'D BY REGIST	RAR 24b REGIS	STRAR'S SIGN	IATURE	
1. E 1+12 do	1 : 11 =	= 1	DATE	APR 1 6 1	59 a	thug &	Kinsk	

the registrar priar ta burial, crematian, ar TO FUNERAL DIRE
page 3 should be TO HEISHITHE CIR VS A15 (4) 15M 10/57

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VS A15 (4) 15M 10/57 c91

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4942 CERTIFICATE OF DEATH

() 4934 Reg. Dist. No.

1.	PLACE OF DEATH					2. US	UAL RESIDENCE	(Wher	e decease	d lived. II	instituti	on-Resid	lence befor	re adm s	nou)
		omico		MARY	YLAND	0.	Maryl				YTHUO		erset		
	b. CITY OR TOWN (IF RURAL and give ne	outside corporate limi	ts, write	c. LENGTH OF STAY	IN 16	c.	CITY OR TOWN ((If out:	side corpo	prote limits	, write R	URAL on	d give nea	rest tow	n)
	Salisbu	ry		2,401 da	ays		Upper F	ai	rmour	ıt	19	7 x			`
	d. NAME OF HOSPITA	AL (If nat in hospital, g	ive street	oddress)		d.	STREET ADDRESS							e. IS RES	IDENCE
		Head State	Hosp	oital											FARM?
3.	NAME OF DECEASED	Fir		Middle			Lost	4	. DATE		Mon	th	Day	γ	Yeor
	(Type or print)	Moo	dy	L.			Muir		OF DEATH		Apr	il	16		19 59
5.	SEX	6. COLOR OR RACE	7. MARR	IED NEVER MARRI	ED 🔟		OF BIRTH			9. AGE (n years	IF UND	ER I YEAR		
	Male	White	WIDOWI	DIVORCE		1	2/17/187	7		81	rthdoy) yrs.	Months	Doys	Hours	Min.
10	a. USUAL OCCUPATIO	N (Give kind of working life, even if relired	done 10b.	KIND OF BUSINESS C	OR INDUS	TRY 11	BIRTHPLACE (Ste	ote or	foreign c			12. (CITIZEN O	F WHAT	COUNTRY?
	Painter	ng me, even it lemed	'	Painting			Marvl	and	1				USA		
13	, FATHER'S NAME					14. A	OTHER'S MAIDE						- 61		
	Lambert 1	Muir					Mary Vi	rgi	nia	Evans	3				
15	. WAS DECEASED EVER			SOCIAL SECURITY NO	17 18	NFORM	ANT HOSD	its	1 Re	cords	n Add	ress			
- ["	Unk.	f yes, give war or dates of s	scrice)					2.00		, ool as					
	18. CAUSE OF DEAT	TH Enter only one co	use per lir	ne for (o), (b), and (c).	1								LINTE	RVAL BE	TWEEN
		H WAS CAUSED BY:		cute heart	-	Barr	e						ONS	Tang	DEATH
	450.0	DUE TO			- 12 040								_	#C 1	цо
	Conditions, if ony, which Arteriosclerosis, general							Year	10						
	gove tise to in	mediote				, ,	5 01102 02							rears	
	couse (o), stating t	he under- DUE TO													
Iz	lying couse lost.	, (c		Charles and the same	. 714 6440										
CATION	PART II. OJRI			ONTRIBUTING TO DE	ATH BUT	NOTRE	LATED TO THE TER	RMIN.	AL DISEAS	E CONDIT	ION GIV	'EN IN PA	ART 1(o) 15	PERFO	AUTOPSY RMED?
Š		inoma of r												YES 🗌	NO 🔣
CERTIF	20a ACCIDENT WAS OR CONTRIBUTING (IF EITHER, NOTIFY A	GUNDERLYING CONTROL CAUSE OF DEATH AEDICAL EXAMINER)	206. DESC	CRIBE HOW INJURY O	CCURRED). (Enter	nature of injury i	in Por	t I or Par	t II of ilem	18.)				
₹	20c. TIME OF INJURY	Month, Doy, Yes	or 20d. It	JURY OCCURRED	20e PLA	CE OF	INJURY (Home, fo	orm,	20f. {City	or town)			(County)		(Stole)
MEDICAL	Hour o m	19	While of worl	Not while	foci	fory, str	eet, office bldg., o	efc.)					, ,,		, ,
-		at 1 attended the			nt.	18.	19 <u>52</u> , lo_	Ar	ril	16	, 59			.1	
		oril 16	105	9	diam'r yn		17.222., 10	OD			1925	",That	l last sa	w the	deceased
	disse our		172.5	9 and that	death	accur	red at	12 P. 9	M, fran	n the co treet, city o	iuses a	nd an	the dat	e state	ed abave:
	ACTUAL SIGNATURE	6 1								,				1 /2	ATE SIGNED
	SIGNATURE	a. from	Same of the same		^	И.D. ,",	Deer s	116	ad o	tate	nosi	olta.		4/1	17.27
	PHYSICIAN'S NAME (Type)	G. Kosmah	ly, M	D.			Salisb	ury	, Ma	rylar	nd				
22	BURIAL CREMATION	22b. DATE THEREO	F-G	23c NAME OF CEM	ETERY OR	CREMA	TORY	22	A TOCK	TION (City	lown, c	or county		Stol	10
4	FUNERAL DIRECTOR'S		-	_ADDRESS	Series	The same			10	us	220	ul	_		
	Denok	Millar	-RA	2	The same	32	Zea!		Y REGIST				SIGNATUR		
4		vocas	Ch Ly	ne w	- CE	-	DATE	AP	R 21	'59	C	rilling	S. Has	wet.	



5M 9/55

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			D STATE DEPARTM		H-BALTIMORE, 1	
		WEDI	CAL EXAMINER	S CERTIFICAT	TE OF DEATH	()4935 Reg. Dist. No.
	g. COUNTY	Wicomico	MARYLAND		Where deceased lived. If Institut yland b. county	dan Residence before admission) WICOMICO
	b. CITY OR TOWN and give nearest to	I (If outside corporate limits, write RURA own) Mt. Hermon	c. LENGTH OF STAY IN 16	11	autside corporate limits, write limits, writ	RURAL and give nearest town)
	d. NAME OF HOS	PITAL OR INSTITUTION (IF not R.D.# Sal	in hospital, give street address) 1.sbury, Md	d. STREET ADDRESS R.	D.# Salisbur	y, Md. YES NO M
	3. NAME OF DECEASED (Type or print)	HENRY	Middle SAMSON	PARKER	4. DATE Month OF DEATH APRIL	28th 19 59
	Male	7 70 4 4	MARRIED NEVER MARRIED DIVORCED DIVORCED	october 20	1893 P. AGE (In years for britiday)	IF UNDER TYEAR IF UNDER 24 HRS. Mogrits Days Hours Min.
	Employe:	TION (Give kind of work done king life, even if refired) e-H.D. Metal nry Parker	Ob. KIND OF BUSINESS OR INDUS	try 11. Birthplace (Stote chinan) Powe 14. Mother's Maiden M Lucy Adk	llville, Md	12. CITIZEN OF WHAT COUNTRY? USA
		EVER IN U. S. ARMED FORCES?	16. SOCIAL SECURITY NO. 17		liams(Daught Delaware	er)R.D.#3
	PART I. DI 33/ X Conditions, if gave rise to imm (a), stating the cause tast.	underlying DUE TO	Outening to DEATH BUT	Herrican Selection of the Terminal Control of the Term	NAL DISEASE CONDITION GIVE	N IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES NO
	CAUSE OF DEAT	H.	SCRIBE HOW INJURY OCCURRED.			
	20c. TIME OF IN.	n.	20d. INJURY OCCURRED 20e. PLA While Not while foct at work at work	CE Of INJURY (Home, farm lary, street, office bldg., etc.	20f. (City or town)	(County) (State)
		that I took charge of I ed fram? Natural caus	the remains described aboves IV, Accident , Su	ive, held an A <u>utaps</u> icide [], Hamicide		Inquiry 🖎 , and find that
	ACTUAL SIGNATURE	ful -	(hye)	M.D. CHIEF MEDICAL EX	_	BATTEROWTH
	EXAMINER'S NAME (Type)	Dr. Earl L.	Royer	DEPUTY MEDICAL		pril 29 1959
	Burial	May 1,195	7 011/41 2 0 3 0 0		22d. LOCATION (City, fown, or D.# Salisbur	y, Maryland
2	HOLLOWA	Y & COMPANY	ADDRESS SALISBURY MAR			RAR'S SIGNATURE



MARYLAND STATE DEPARTMENT GREATH-BALTIMORE, 18

CERTIFICATE OF DEATH

04936

4943

Reg. Dist. No....

	I. PLACE OF DEATH	2. USUAL RESIDENCE (HOME) OF DECEASED
	COUNTY WICOMICO MARYLAND	STATE Maryland COUNTY Wicomico
	CITY III outside compounts limits surite PUP àl	CITY (If outside corporete limits, write RURAL and give nearest town) OR
	OR and give nearest fown) Town Salisbury, Md. Since 4/11/58	X TOWN Parsonsburg
	HOSPITAL OR Pine Bluff State Hospital	STREET (If rurel give location)
4	STREET ADDRESS Salisbury, Maryland	/ ADDRESS
	3. NAME OF (First) (Muddle)	(Last) 4. DATE (Month) (Day) (Yoar)
	(Type or Print) Minnie Lillian	Parker DEATH April 10 19 59
	S. SEX 6. COLOR OR 7. SINGLE, MARRIED, B. DATE OF	F BIRTH 9. AGE lest birthdey IF UNDER 1 YEAR IF UNDER 24 HRS.
	Female RACE White Specify Married Oct. 2	28, 1880 78 yrs. Months Days Hours Min.
	10a, USUAL OCCUPATION (Give kind of work 10b, KIND OF BUSINESS	11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?
	done during most of working life, even if retired) Housewife —	Parsonsburg, Maryland USA
	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
	James Campbell	Sophia Baker
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
	(Yes, no, or unk.) (If Yes, give wer or detes of service)	Records of Pine Bluff State Hospital Md. Albert Parker-Parsonsburg, Md.
	18, MEDICAL CER	TIFICATION INTERVAL BETWEEN
	I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	ONSET AND DEATH
	IMMEDIATE CAUSE (A) Pulti	monary Tuberculosis 3 yrs.
	ANTECEDENT CAUSE(S) DUE TO Arteriosclerotic CE	ardiovascular disease 5 yrs.
	COUNTY OF TO THE ADDITIONAL OF THE PARTY OF	
М	STATING UNDERLYING CAUSE LAST. DUE TO (C)	
	11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE	
	DISEASE OR CONDITION CAUSING DEATH.	
٥	19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES NO 🛣
		Ic. WHERE DID INJURY OCCUR? (City or fown) (County) (Stele)
	OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bidg., etc.) (IF EITHER, NOTIFY MEDICAL EXAMINER)	
	21d. TIME OF INJURY (Month) (Day) (Yeer) (Hour) 21a. INJURY OCCURRED While Not white	21f. HOW DID INJURY OCCUR?
	M. et work	
	22. I hereby certify that I attended the deceased from April 1	
1	alive on April 10, 1959, and that death occurred at	LO:53p.M, from the causes and on the date stated above.
10.M-	Edward P. Ritching M.D.	ADDRESS (Street, city, town, state) DATE SIGNED
-55	23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR	Salisbury Md. 1/11/59 CREMATORY LOCATION (City, town, or county) (State)
A15C 1-55	PEMOVAL (SPECIFY)	
	Burial Apr. 14, 1959 Parsonsbi	urg, Cemetery Parsonsburg, Md. 1 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
λ2	ADD 4 P ICO	HOLLOWAY & COMPANY -SALISBURY MD.
	APR 15'59 Chilling & House	INDITIONAL & CONTINUT SOUTISEOUT UN.

The law imquires that the Leath certificate be eximited with INSTRUCTIONS

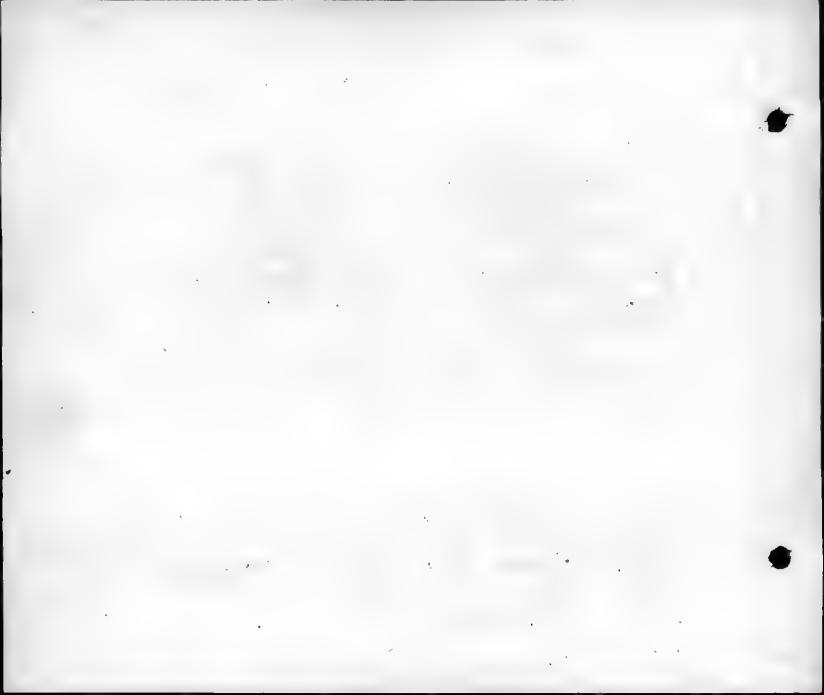
or use as a burial transit permit.

or attending physician.

The bottom copy may be retained by the posptre TO FUNERAL DIRECTOR: The law requesticate has been executed by the death certificate assembly should be de



1		- .	ems 18% Film 242 5-11-59 ams	IT OF HEALTH-BALTI	MORE, 18
		17	ems 18% Film 242 5-11-59 ams CERTIFICATI	E OF DEATH	() 4937 Reg. Dist. No.
4 th . 1		1 6	AND AND LITHOUTE DEFEND	7 6 9	ed If institution, Residence before admission)
Page 1	ĺ.,	1. 6	COUNTY	a_STATE	b. COUNTY
= 0		ŀ	CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporale	limits, write RURAL and give nearest town)
d bi			RURAL and give negrest town)	Patis bur	°4′
ah ou	>	-	NAME OF HOSPITAL (If nat in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
in by and 2	*	1	MINSULA VENEUL		YES NO
- G		1	IAME OF ECEASED (Middle SCENE) (Middle SCENE) (Middle SCENE)	OF DEATH	Month Day Year 19.59
thin 2		5. 9	U) EPICO	ATE OF BIRTH 9.	AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS
T See K)	1	Kin Le White WIDOWED DIVORCED VI	NUL. 14, 1795	ast birthday) Months Doys Hours Min
Com		10a	USUAL OCCUPATION (Give kind of work done lob. KIND OF BUSINESS OR INDUSTRY during most of working life, eventif paired)	11. BIRTHPLACE/(State or foreign count	12. CITIZEN OF WHAT COUNTRY
ond bon er de		13.	ATHER'S NAME	4. MOTHER'S MAIDEN NAME	CA. 4. C.
cion cion car s offi			Queces Morris	Day 19	Bart.
tifice shysi mave h≡ur		15	A	RMANT	Address
ng p			Diffee 90	he forler	tolistery 71
deotl tend oleas ithin			18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
the at			PART I. DEATH WAS CAUSED BY: Cerebral hemor	rhage	/ 6 hrs.
hat by th			Canditions, if any, which) Essential hype	rtension	2 yrs.
res Primi			gove rise to immediate		
sit pr			lying couse last. (c)		
ow r rsicio been trans		CATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT	FRELATED TO THE TERMINAL DISEASE CO	OND TION G VEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
The la	0	FCAI			YES NO 5
ending ficate the bu		CERTH	200. ACCIDENT WAS UNDERLYING [] 206. DESCRIBE HOW INJURY OCCURRED. (E OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	nier noture of injury in Pott I or Pori II	of item (6.)
r oth certification,		ICAL	fastani	OF INJURY (Home form, 20f. (City or , street, office bldg., etc.) !	tawn) (County) (State
PHI bal o this or use remo		MEDI	P. m. 19 While Not while p. m. 19 of work all work		
aspii ospii ospii ospii ospii ospii			21. I certify that saitended the deceased from 4/28	, 19 9 , to 4/29	, 192_,that I last saw the decease
ENDI ne ho R: Af achee			alive an 7/19 and that death ac		causes and an the date stated above
d d			SIGNATURE AND MILE MANAGEMENT M.D.	Later allers	111/11/11/11/11
OR ined DIRE	1		17	25,0000,090000	
retai RAL I Shoul			PHYSIGIĀN'S NAME (Type)	to confere the last offers the	
HOSP loy be FUNE age 3		22 a	BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CR	REMATORY 22d. LOCATION	N (City, fown, or county) (State)
DO HO		22	Survey 3//3 9 Earloy	Voh	RSLEEP 173
VS A15 (4)		23.	Brilder Ingresia Palkeri	24g. REC'D BY REGISTRAL	4. 24
15M 9/58		-	Juliano James	// 4 59	Christing S. Thous
		E	//		



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VS A15 (4) 15M 9/55

ARYLAND STATE	DED A DTMEN	T OF HEALTH	DAITIMADE	10
AKI PAMA SIMIE	PECHUINEL	I OLIEVELLI—	DALIIMOKE,	10
T+am 7	Maria Contract Land	umhaby et	•	

4945 CERTIFICAT

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CERTIFICATE OF DEATH

Reg. Dist. No. 38

\ [1. PLACE OF DEATH a. COUNTY			2	USUAL RESIDENCE (Wit	here decease		an: Residen	ce befo	re odmiss	ion)
	Wice	omico	MARYLAN	2	Maryla	and	b. COUNTY	Wor	cest	ter	
4	b. CITY OR TOWN (If our RURAL and give neares	Iside carparate limits, write	c. LENGTH OF STAY IN 1	6	c. CITY OR TOWN (IF o	outside corpo	orale limits, write R	URAL and g	ive nec	rest lown)
H	Sali		371 days		0cean	City		, ; X			V
ı	d. NAME OF HOSPITAL (If not in hospital, give street o	oddress)		d STREET ADDRESS					e. IS RESI	
ı	Deer's H	Head State Hos	pital		203 N	2nd	Street				NO X
ı	3. NAME OF DECEASED	First	Middle		Losi	4. DATE	Man	th	Do	у Ү	lear .
L	(Type or print)	Hattie	Louise		Quillen	DEATH	Apr	il	1	1	1959
	5 SEX 6.	COLOR OR RACE 7 MARR	ED 🔲 NEVER MARRIED 🖥	B. D	ATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER			
ı	Female	White WIDOWE	100		May 28, 189		65 yrs.	Monnt	Days	Hours	Min.
	100 USUAL OCCUPATION (Give kind of work done 10b. life, even if retired)	KIND OF BUSINESS OR IN	DUSTRY	11. BIRTHPLACE (State	or foreign c	ountry)	12. CIT	IZEN O	F WHAT	COUNTRY
L	170025V	VIFG 0	WN HOME		Ocean (City.	Maryland		Į	JŞA	
	13. FATHER'S NAME			14	MOTHER'S MAIDEN N	NAME					
1	Robert	C. Quillen			Hat	tie He	enman				
ſ	15. WAS DECEASED EVER IN	U. S. ARMED FORCES? 16	SOCIAL SECURITY NO. 17	INFO			Add	ress			
	Unk	No		I	Mospital Reg	cords.	Salisbu	ry. Na	aryl	Land	
		[Enter only one couse per lin	e for (a), (b), and (c).]						INTE	RVAL BE	TWEEN
-	PART I. DEATH \	WAS CAUSED BY: GE	eneralized ca	rci	nomatosis				UNS	? AND	DEATH
1	17/0×	DUE TO									
-	Canditions, if any,		of breast						1 3	yea	irs
1	gave rise to imme										
-	lying cause lost.	(c)									
	PART II. OTHER S	SIGNIFICANT CONDITIONS C	ONTRIBUTING TO DEATH	UT NOT	RELATED TO THE TERM	INAL DISEAS	E CONDITION GIV	EN IN PART	1 (o) 1	9 WAS A	UTOPSY
	3	Mult	iple scleros	is							NO
-	PART II. OTHER S	NDERLYING 1 206 DESC	RIBE HOW INJURY OCCU	RED (E	nter noture of injury in l	Part I or Par	rt II of item 1B }				
-		DICAL EXAMINER)									
-	20c. TIME OF INJURY /			PLACE	OF INJURY fHome, form street, affice bldg , etc	20f. (Cil)	y or lown)	(C	County)		(State)
1	p. m.	19 While of work	Not white	,							
-	21. I certify that	I attended the decease	d from March	25	, 19.58 to	April	1 1959	that	ast so	w the	decease
-	alive on_Apri	19 5			curred at 1:15						
1		/////	,				ilreel, city or town,				TE SIGNE
Л	SIGNATURE D	- Maldly	,	M.D.	Deer's H	ead St	tate Hosp	ital		4/1	/59
	PHYSICIAN'S	T TT 34 3 3	15 D				-				
	NAME (Type)	L.V. Maldve,	M. D.		Salisbur	ту, Ма	ryland	·			
	22a. BURIAL, CREMATION, REMOVAL (Specify)	226. DATE THEREOF	22c. NAME OF CEMETERY	OR CR	EMATORY		TION (City, Iown,			(Stote	r)
	BURIAL	114159	EVER	6- K	25EIV	13	GRUIN			14	1)
	23. FUNERAL DIRECTOR'S SI	GNATURE /	ADDRESS /3	0	240. REC	D BY REGIST	TRAR 24b REGIS	STRAR'S SIC	NATUI	RE .	
	Johnson	Ja. Buch	age ple	U.	CC / GO DATE	• 11 0	υυ α		, 7 65A	~~~	



CERTIFICATE OF DEATH

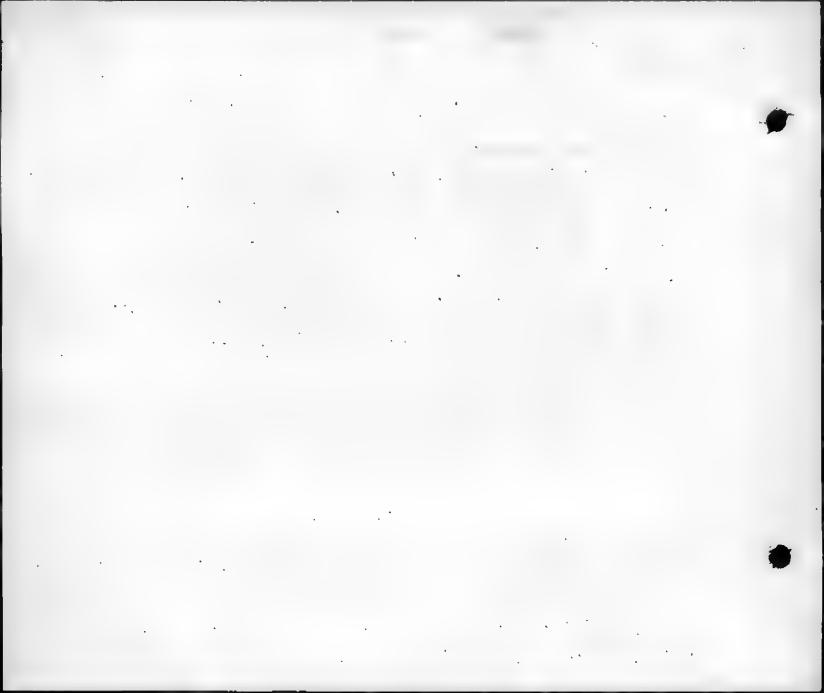
04939

	2030 CEKTIFICAT	Reg. Dist. No.
1	1. PLACE OF DEATH 0. COUNTY MARYLAND MARYLAND	USUAL RESIDENCE (Where deceased rived. If institution: Residence before admission) o STATE b COUNTY
,	b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest tawn)	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
	d. NAME OF HOSPITAL (I nat in haspital, give street address) OR INSTITUTION	d. STREET ADDRESS e IS RESIDENCE ON A FARM YES NO
-	3 NAME OF DECEASED (Type or print) ANN ANN ANN ANN ANN ANN ANN ANN ANN AN	Last 4. DATE Manth Day Year
	5 SEX 6. COLOR OR RACE 7 MARRIED NEVER MARRIED 8.	DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 H last birthday) Months Days Hours Min
)	100 USUAL OCCUPATION (Give kind of work dane during most of working life, even if retired) DIVORCED DIVORCED DIVORCED DIVORCED	
	13 FATHER'S NAME	14. MOTHER'S MAIDEN NAME
		ORMANT Address
	18. CAUSE OF DEATH [Enter anly one cause per line for (a), (b), and (c).]	INTERVAL SETWEEN IONSET AND DEATH
	PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o) DUE TO	12 Metect 1.haif
	Canditions, if any, which gave rise to immediate cause (a), stating the under-	
47	lying cause last. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO	OT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPPERFORMED? YES NO
		(Enter nature of njury in Part I ar Part II af item 18.)
		E OF INJURY (Hame, farm, 70f. (City ar tawn) (Caunty) (Starty, street, office bldg , etc.)
	21. I certify that I attended the deceased fram. 4-15	, 19.2 /, ta CF-/2 , 19.2 /that I last saw the deceas
	ACTUAL (C) (C)	ADDRESS (Street, city or town, state) ADDRESS (Street, city or town, state)
Canal Canal	PHYSICIAN'S NAME (Type)	Sand Comment of the first of the sand of t
	220 BURIAL CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR G	EREMATORY. 22d, LOCATION (City town, or county) (State)
	23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	240. REC'D BY REGISTRAR 246. REGISTRAR S SIGNATURE DATAPR 2 1 '59 Cultury & House

may be retained the hospital or ottending physician.

D FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the control of the page 3 should be detached for use as the burial-transit permit. Then please remained corbaptions to page 3 should be detached for use as the burial-transit permit. Then please remained after detached for use as the burial-transit permit. Then please remained the detached for use as the burial, cremation, or remayal, and in any event within 72 hours after death. death. Page 4 ETENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after may be retained TO FUNERAL DIRES TO HOSPITAL OR

VS A15 (4) 15M 9/58



be faled with

death. Fage 4

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 4960

CERTIFICATE OF DEATH

	2003		TIR OI DRAII	•	Reg. Dist	l. No.	
o. COUNTY	Wicomico	MARYLAND	2. USUAL RESIDENCE (WHO o. STATE Mary	ere deceased lived. I	f institution Residence	e before admission) MICO	
B. CITY OR TOWN (SURAL and given (HUPAL)	If outside corporate limits, write eurest town! Salisbury	c. LENGTH OF STAY IN 16	C. CITY OR TOWN (IF o	utside corporate fimits sbury (Ru		ve negrest town)	
d name of Hospii Or Institution	FAL (If not in hospital, give street $R_*D_*\# 3$ ()	oddress) Valston)	d. STREET ADDRESS R.D.	# 3 (Wal	ston)	e. IS RESIDENCE ON A FARM YES 17 NO	VI?
NAME OF DECEASED (Type or print)	GEORGE	Middle WALTER	SMITH	4. DATE OF DEATH	APRIL.	Ony Yeor 4th 195	9
Male Male	White WIDOW	DIVORCED	B. Date of Birth Dec. 30, 189	_	41.1	YEAR IF UNDER 24 H	
Retired	ON (Give kind of work done 106 king life, even if retired) Employee (Mains		kers Wico	mico Co.	Maryland	TEN OF WHAT COUR	
B. FATHER'S NAME			14. MOTHER'S MAIDEN N				
	ashington Smi			E. Hear	<u>-</u>		
YES YES	R IN U S. ARMED FORCES? 16. (If yes, give wor or defee of service) W. W. #1	SOCIAL SECURITY NO.	s.Henrietta (Walston)	G.Smith Salisb	(Wife)R. ury, Mary	D.#3 land	
Conditions, if o gave rise to i couse (o), stoting lying cause lost	mmediate the under DUE TO (c)	conory &	tery Aus lin Echa-gr	sore	anth Contings	i enere	
200 ACCIDENT W	HER SIGNIFICANT CONDITIONS C	CRIBE HOW INJURY OCCURRE	*			I(o) 19 WAS AUTOF PERFORMED YES NO	. 50
CONTRIBUTING	CAUSE OF DEATH MEDICAL EXAMINER)		and famous or migray me				
20c TIME OF INJUR Hour a. m. p. m.	Y Month, Day, Year 20d. it While of work	Not while fe	ACE OF INJURY (Home, form, clory, street, office bldg., etc.	20f. (City or town)	(Ce	ounty) (Sh	lote)
21. I certify the alive on	House &		accurred at 2:05	M, from the co	auses and an the	e date stated of	bove
PHYSICIAN'S Dr		11 Jr 🚶	Pine Bluff	Road S	alisbury	,Marylan	d
REMOVAL (Specify)	Apr. 7, 1959	Wicomico M	er crematory Jemorial Par	22d. LOCATION (CIT) k Sali	y, town, or county) sbury, Ma	ryland	
HOT TOWAY		ADDRESS		_	46 REGISTRAR'S SIGN		
HOLLOWAY	& COMPANY	SALISBURY M	ARYLAND DATE AP.	R 9 '59	arthur 8.	Thous	

ATTENDING PHYSICIAN: The low requires that the death certificate He executed within 24 hours after the hospital are attending physician.

After this certificate has been signed by the attending physician and campletely filled in by the After this certificate has been signed by the attendance carbon papers. Pages 1 and 2 haviol crematian, at remayal, and event within 72 haurs after death. may be retained frithe hospital or attending physicia
TO FUNERAL DIRE
R: After this certificate has been
page 3 should be advached for use as the burial-trans
the registrar priar ta burial, crematian, ar remaval, ay TO HOSPITAL OR

VS A15 (4) 15M 10/57



2	MARYLAND STATE DEPARTA	MENT OF HEALTH—BALTIM	ORE, 18
	4970 CERTIFIC	ATE OF DEATH	()4941 Reg. Dist. No.
	• COUNTY WICOMICO MARYLAND	2. USUAL RESIDENCE (Where deceded lived, o. STATE	It institution, Persence before admission)
	b. CIPY OR TOWN (if outside corporate limits, write c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (I) outside corporate lim	
X	d NAME OF HOSPITAL/III not in hospital, give street oddress	d. STREET ADDRESS	e. IS RESIDENC ON A FARM YES \(\) NO
	NAME OF DECEASED (Type or print) (Type or print) (Type or print)	Man Royal DEATH	Charle Day Year
	SSEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED	· · · · · · · · · · · · · · · · · · ·	(I) years IF UNDER I YEAR IF UNDER 24 Hours Mill
	Oa USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDI- during most of working life, even if retired)	ISTRY M. BIRTHPLACE (Slote or foreign county)	12. CITIZEN OF WHAT COUN
Ī	3. FATHERS NAME (Orlivarel). Johnson	14 MOTHER'S MATTEN NAME	
ī	5 WAS DECEASED EVER IN U. S. APMED FORCES? 16 SOCIAL SECURITY NO. 17.	INFORMANT 110 X	Address
=	18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c)] PART I. DEATH WAS CAUSED BY:	o agnisory is any	INTERVAL BETWEE
	420, DUE TO	ry Medern	17.
	Conditions, if any, which gove risa to immediate DUE TO	CVI Desi	hal
	lying cause lost. (c)	rleusion	
0	5	T NOT RELATED TO THE TERMINAL DISEASE CONE	YES NO
	200. ACCIDENT WAS UNDERLYING A 200 DESCRIBE HOW INJURY OCCURRE OR CONTRIBUTING CAUSE OF DEATH OF THE OFFICE OF THE	D. (Enter nature of injury in Port I or Part II of it	em 1B.)
2	20c TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED to Hour a. m. 19 While of work at work	ACE OF INJURY (Hame, form, 20f. (City or law clary, street, office bldg., efc.)	n) (County) (Ste
	21. I certify that I attended the deceased from 4/1/1/2	59.127, ta 4/13	, 1947, that I last saw the dece
	alive an 1927 and that death	accurred ofM, from theMSSSS (Street, c)	couses and an the date stated above town, state)
1	SIGNATURE DR. WILLIAM B. SMITH	M.D. Med lester Sty	14, 4/13/
',	PHYSICIAN'S NAME (Type)	0 (
2	TEMOVAL ISPOSTY) 226 DATE THEREOF 226 NAME OF TEMETERY C	110 -1	ry lowns of county) All Slote
2	3 PUMBRAL DIRECTOR'S SIGNATURE AMERICA	240. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
	coming or James snowhelly	my DATE APR 1 5 '59	Citiza & House

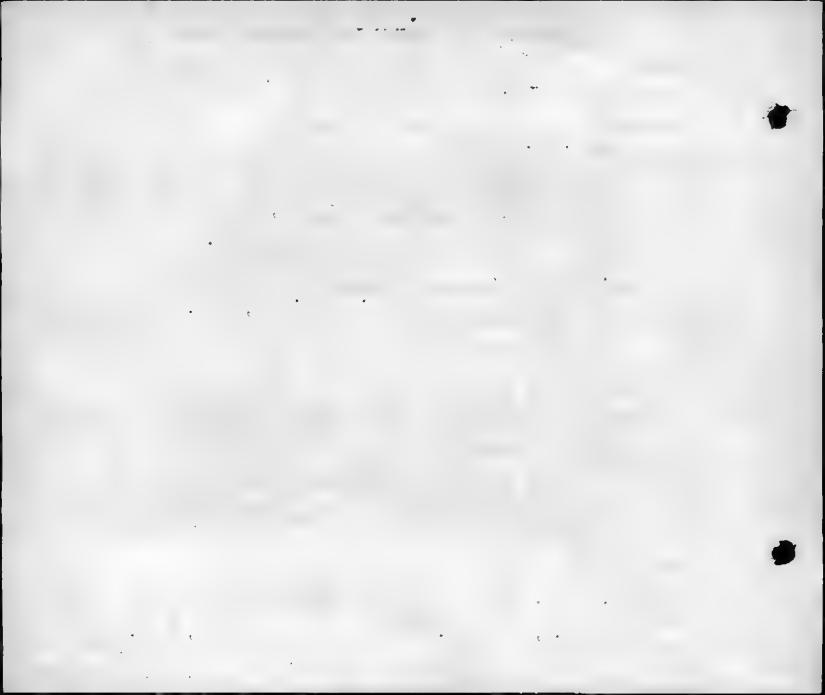


VS. A15ME(S) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4947 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 $\underset{\text{Reg. Dist. No.}}{\text{()}} 4942$

	A. COUNTY WICOMICO	MARYLAND	2. USUAL RESIDENCE (V			ence before adm Affolk	isson}	
1	b. CITY OR TOWN IIF outside corporate limits, write RURAL	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (IF	outside corporate	limits, write RURAL on	d give nearest to	wn)	
	and give nearest town Salisbury	Boston (Brighton) 5%						
	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS . IS RES			ESIDENCE		
	Pen.Gen. Hospital		1568 Commonwealth VES NO I					
	3. NAME OF First DECEASED	Middle	Lost	4. DATE	Month	Day 1	fear	
	(Type or print) I.II.I.IA	.N	STEWART	OF DEATH	APRIL	3rd 1	9 59	
	5. SEX 6. COLOR OR RACE 7. MAI	RRIED NEVER MARRIED 8.	DATE OF BIRTH	9. AG	E (In years IFUNDER		ER 24 HRS.	
		VED M DIVORCED		,1899 6	O yes. O	Days Hours	Min.	
	10a. USUAL OCCUPATION (Give kind of work done 10th during most of working life, even if retired)	On. USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (Stole or foreign country) 12. CITIZEN OF WHAT COUNTRY?						
	House Work at Home Unk Everette Mag					USA	<u>1</u>	
	13. FATHER'S NAME		14. MOTHER'S MAIDEN N					
	Edward A.Galley Jeannette							
	15. WAS DECEASED EVER IN U. S ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Mr. Leon A. Galley (Brother) #70Nep				Nepons	set Av		
	No		Dorchest	er, Mas	S			
	18. CAUSE OF DEATH [Enter only one couse per line fof (o), (b), and (c).] PART I, DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH		
	IMMEDIATE CAUSE (o)						X	
7	DO OF ALL O DUE TO						0	
	Conditions, if any, which (b) gave rise to immediate cause							
	(a), stoting the underlying DUETO							
d f	PART II. OTHER SIGNIFICANT CONDITIONS 200. EXTERNAL CAUSE WAS PRIMARY FOR CONTRIBUTING CAUSE OF DEATH	PERFORMED?						
	200. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part Laury ort 11 of item (5.)							
	CAUSE OF DEATH.							
	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 22f. (Cry or Jown) (County) (Stote) Address, street, office bldg., etc.)							
	8-Hour a.m. 3-23 1959 While Not while of work							
	21. I certify that I took charge of the remains described above, held an Autopsy X, Inspection X, Inquiry X, and find that							
	death resulted from; Natural causes	, Accident , Suid	cide 🔲 , Hamicide	, Undete	rmined cause].		
	10. 1							
	SIGNATURE M.D. CHIEF MEDICAL EXAMINER						SIGNED	
ر م در نم	EXAMINER'S D. T. T. T.	EXAMINER'S D. F. T. B. ASSISTANT MEDICAL EXAMINER April 3 / 1959						
	NAME (Type) Dr. Barl L. Hoj		DEPUTY MEDICAL	EXAMINER .) , -,,		
220. BURIAL, CREMATION, 226. DATE THEREOF 22C. NAME OF CEMETERY OR CREMATORY					City, town, or county)	(Stot	•)	
	Burial Apr. 7, 1959	Mt. Hope Ce			n, Mass.	7.11.T.10.T		
	HOLLOWAY & COMPANY *		RYLAND DATEP	D BY REGISTRAR	246. REGISTRAR'S SH	CAMA		
	HOLLOWAL OF CONFAMIL "	PUTTODOUT LIVI	DATE					



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4943

CERTIFICATE OF DEATH

Reg. Dist. No.

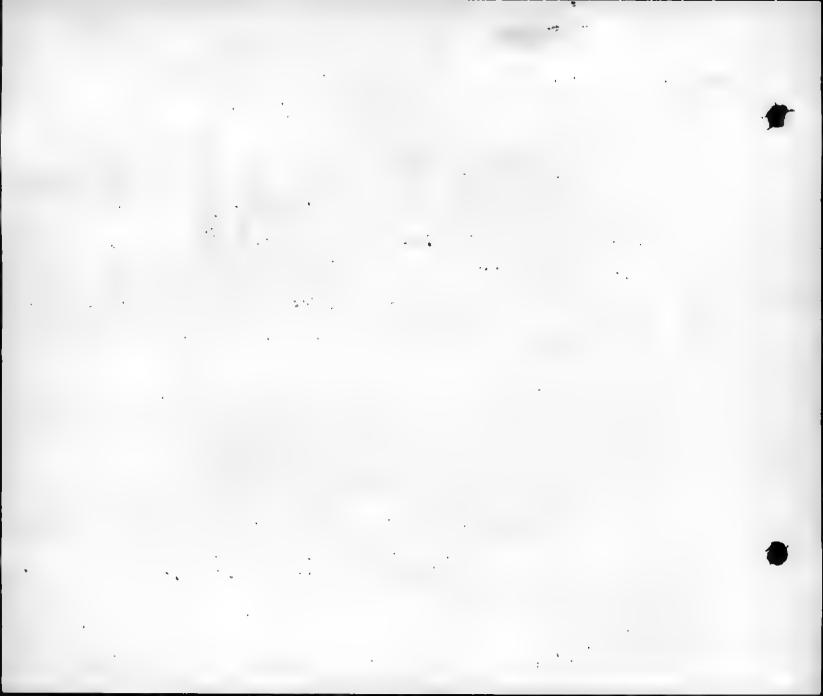
-	1. [PLACE OF DEATH D. COUNTY	MARYLAND	2. USUAL RESIDENCE (When	re deceased lived. If institution: Residen	ce before admission) OFRSET	
Š),	D. CITY OR TOWN (If outside carporate limits, write c LENGTH (OF STAY IN 16	CITY OR TOWN II AND	tside corporate limits, write RURAL and	/	
_		PLIPAL and give negrest town?	0 E E K 5.	5 /	NONA //	give medical ranny	
		d. NAME OF HOSPITAL (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE	
	P	ENINSULA GENERAL HOSP	ITAL	MAIN	FOAD	YES NO	
		NAME OF First PERMAN F.	Middle	CT N E	4. DATE . Month OF DEATH A PRIL	Day Year 2 1959	
	5 5		R MARRIED	8 DATE OF BIRTH	9. AGE (In years IF UNDER	1 YEAR IF UNDER 24 HRS	
	N	MALE WHITE WIDOWED 1	DIVORCED [NEC-21-19	00 5 yrs. Months	Doys Hours Min	
	10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY (1) BIRTHPLACE (State or foreign country)						
	(Jeafood. Wajen	man	On any	Tand	4.5.71	
	13. FATHER'S WAME 14. MOTHER'S MAIDENTHAME 14. MOTHER'S MAIDENTHAME 14. MOTHER'S MAIDENTHAME 15. MARY PARKINSON						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT (Yes, no. or unknown) (If yes, give wor or dates of service) 220-12259 Prescilla STine-Weson							
						one my.	
		18. CAUSE OF DEATH [Enter only one couse per line for (o), (b),	ond (c).]	1 11 01		INTERVAL BETWEEN	
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) DUE TO	mazu	il peace	Seslase	enterroun	
		00010					
		Conditions, if ony, which (b)			1	. 1	
		couse (o), stoting the under. lying cause lost. DUE TO (c)	nond	4 Emp	lugerna	1 /	
	CATION	PART 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING	G TO DEATH BUT	NOT RELATED TO THE PERMIN	IAL DISPASE CONDITION GIVEN IN PAR	T 1(a) 19. WAS AUTOPSY PERFORMED?	
0						YES NO	
	CERTIF	20g. ACCIDENT WAS UNDERLYING ☐ CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	4JURY OCCURRE	D. (Enter noture of injury in Po	ort I or Part II of item 18.)		
	MEDICAL	20c. TIME OF INJURY Month, Day. Year 20d INJURY OCCUI	- form	ACE OF INJURY (Home, form, clary, street, office bldg., etc.)	20f. (City or town) (I	County) (State)	
	ME	Hour a.m. While Not whi p.m. 19 of work of work					
		21. I certify that I attended the deceased fram	3:2	/, 19.5.7, ta	7 7, that I lo	ist saw the deceased	
		alive an 4 - 3 , 19 2 7 , an	d that death		A, fram the causes and an the DDRESS (Street, city or lown, stole)	e date stated above. DATE SIGNED	
		ACTUAL / 12 Office R 900	1,0.	500	DORESS (SINEEC, City or lown, stole)	(i - 7 - 59	
1		SIGNATURE COLUMN CX - TWO	1	M.D.	200 - 100 -	·	
		PHYSICIAN'S NAME (Type)		any game to a spine seem to the total gaps that gard total spin was sold seems.			
	220	BURIAL, CREMATION, 22b DATE THEREOF 22c. NAME	OF CEMETERY O	-	22d LOCATION (City town, or county)	(State)	
	_/	Barist april 5-1909 St. Pauls mellouist Work one one.					
	23.	FUNERAL DIRECTOR'S SIGNATURE ADDRES	200	フノルス I・APR	8 '59 Carthan &	4 -	
		- Junion - Lago	1-0-2	DATE	CONTRACT 2,	/ PEARLE	

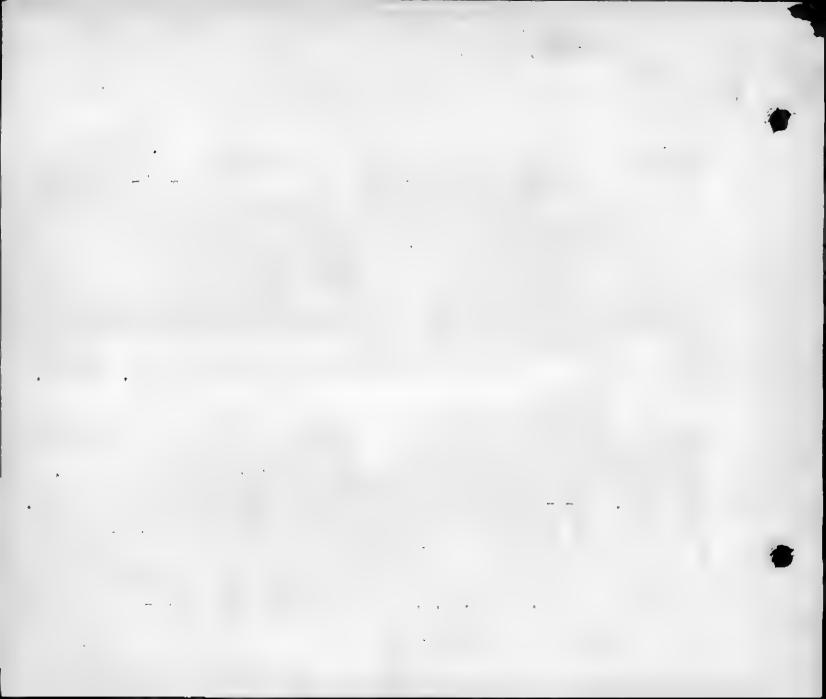
may be retained the haspital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the filed director, page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shauld be filed with the registrar prior to burial, crematian, or removal, and in any event within 72 hours after death. eath. Page 4 TO HOSPITAL OR ATTENDING PHYSICIAE: The low requires that the death certificate be executed within 24 hours after may be retained to haspital at alternating physician.

Solve TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the page 3 should be detached for use as the burial-transit performs. Then please remove carbon pages. Pages 1 and 2 sha

in on





VS A15 (4) 15M 9/58

a. IS RESIDENCE ON A FARM?

Hours

INTERVAL BETWEEN

ONSET AND DEATH

WAS AUTOPSY PERFORMED? YES INO IX

(State)

DATE SIGNED

(Stote)

(County)

Chillian

DATE

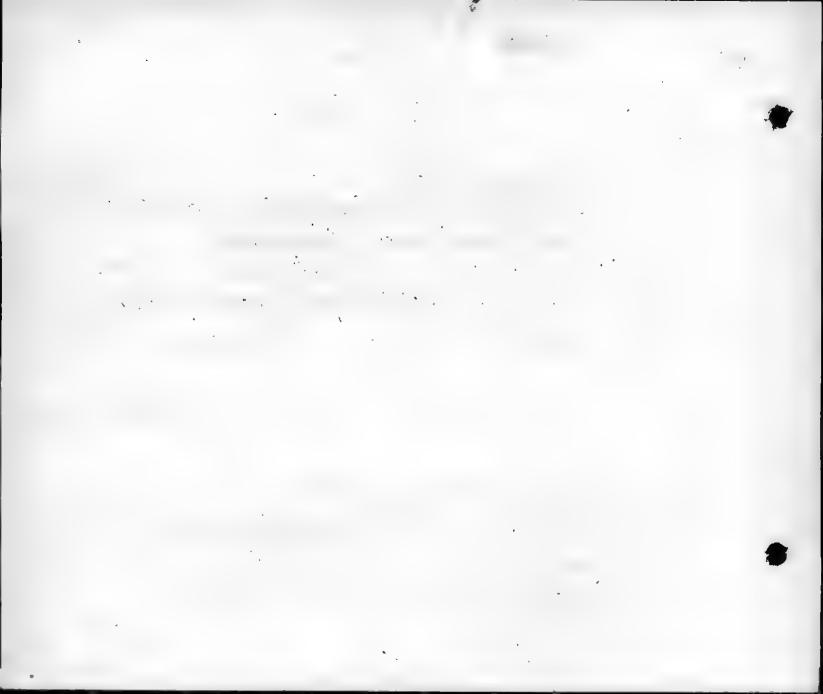
YES NO IV

Year

19.59

c02m

Day



death. Page 4

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 4951

CERTIFICATE OF DEATH

04946

Rea. Dist. No

- h-							
Ī	1. PLACE OF DEATH O. COUNTY WICOMICO MARYLAND	USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY b. COUNTY					
F	b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
	RURAL and give nearest lown)	TRANKTOKD Del. V					
Γ	d. NAME OF HOSPITAL of nat in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS e. IS RESIDENCE ON A FARM?					
	Peninsula General Hospital	4. D YES NO					
3	3. NAME OF DECEASED (Type or print) (A S S O N Middle	Lost 4. DATE Month Day Year DEATH CLOCK 21 1959					
-	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8 D	DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Iss birthday) Months Days Hours Min					
	male white WIDOWED DIVORCED 4	-/23/190/ 5/ yrs.					
1	10a. USUAL OCCUPATION (Give kind of work done of the lobe to the lobe of the l	1/0-					
	MERCHANT	MARYLAND 9.5A.					
1	13. FATHER'S NAME	4. MOTHER'S MAIDEN NAME					
-	15. WAS DECEASED EVER IN U. S ARMED FORCES? [16. SOCIAL SECURITY NO.] INFO	PRMANT _ Address					
ľ	[Yes, no, or unknown] [If yes, give wor or dotes of service]	12ABETH THOMAS FRANK FORDL					
ŀ	1B. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c),]	INTERVAL BETWEEN					
1	PART I. DEATH WAS CAUSED BY:	Che y De Car U.C. C.					
1	331X IMMEDIATE CAUSE (a)	the first of the f					
1	Conditions if any which I						
1	gave rise to immediate DUTTO						
	lying cause last. (c)						
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO	T RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?					
	N N N N N N N N N N N N N N N N N N N	YES NO L					
	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	Enter noture of injury in Port I or Port II of item 18.)					
	Hour o.m. 16 While Not while foctory	OF INJURY (Home, farm, 20f. {City ar town} (County) (Slote) y, street, affice bldg., etc.)					
1							
1	21. I certify that I attended the deceased fram.	, 19, ta, 19, that I last saw the deceased					
1	alive an						
/	SIGNATURE Willer C. Philes, M.D. Jiele Cieri Mill 4 21.5						
1	PHYSICIAN'S NAME (Type)						
7	220 BURIAL, CREMAT.ON. 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CI	REMATORY 22d, LOCATION (City, town, or county) (State)					
- 12	BURIAL +124/3/ NEDMENS, C	em. JAGSBORD DP1.					
2	23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24g REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE					
L	Walson & Tray raupsord I'll	DATE APR 2 4 '59 Culling & House					

may be retained to the After this certificate has been signed by the attending physician and campletely filled in by the wineral director.

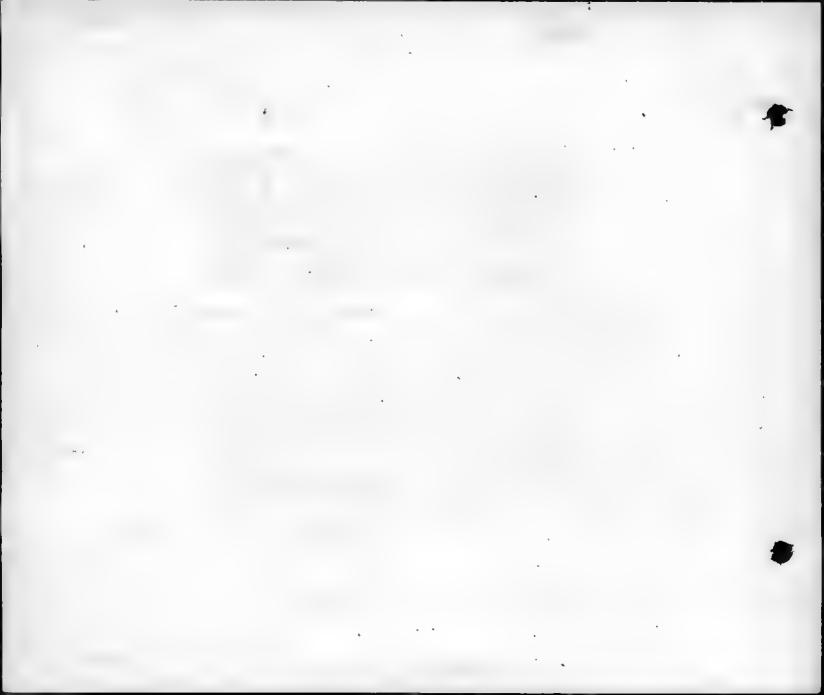
3 FUNERAL DIRECTOR After this certificate has been signed by the attending physician and campletely filled in by the wineral director. After this certificate has been signed by the attending physician and a should be filed with page 3 should be deathered. Aggles 1 and 2 should be filed with page 3 should be deathered. may be retained TO FUNERAL DIR

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4953 MEDICAL EXAMINER'S CERTIFICATE OF DEATH **FOR STATE** HEALTH DEPT PLACE OF DEATH Page

Rea. Dist. No. 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. COUNTY **a** STATE b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL c. LENGTH OF STAY IN 16 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) and give negrest town) 16 hrs. d NAME OF HOSPITAL OR INSTITUTION (If not in hospito), give street address) e IS REJIDEN JE ON A FARM? d STREET ADDRESS YES NO R NAME OF 4. DATE Middle Month Year DECEASED OF (Type or print) DEATH -e -e 19 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 1 8. DATE OF BIRTH AGE (In years IFUNDER TYPAR IF UNDER 24 HSS 3 3 Months Days Hours Min. WIDOWED [7] DEVORCED [7] 10g. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State of fareign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if ratired) US. Truck Driver Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Wires Edward Truitt Elsie Mae Dennis 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address 18. CAUSE OF DEATH [Enter only one cause per line-for (a), (b), and (c). INTERVAL BETWEEN DNSH AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUF TO Conditions, if ony, which gave rise ta immediate cause DUE TO (a), sloting the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? NOF 200. EXTERNAL CAUSE WAS PRIMARY OF OF DEATH. 20b DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Part I of Fart II of Item 18.) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.) i 20f. (City or fown) (County) (Stote) While A 00 at work of work p. 63. 21. I certify that I took charge of the remains described above, held an Autopsy ... Inspection [7] Inquiry (4) ond in my opinion death resulted from: Natural causes . Accident . Suicide [], Homicide |], Undetermined manner DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER SIGNATURE ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER TH NAME (Type) 220. BURIAL, CREMATION, 226. DATE THEREOF 22d. LOCATION (City, town, or county 22c. NAME OF CEMETERY OF CREMATORY (Slote) 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 240 REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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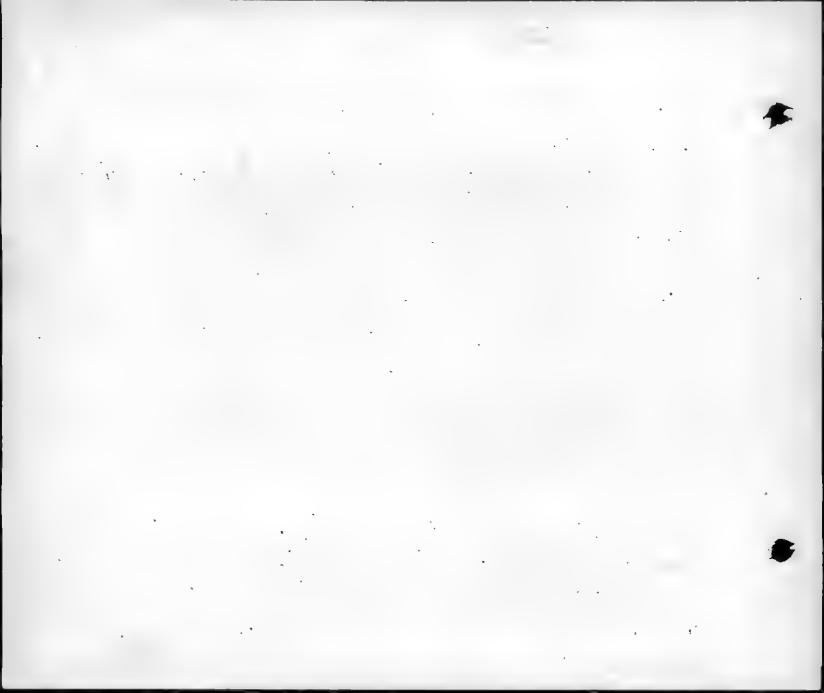
designated



4954 CERTIFICATE OF DEATH Reg. Dist. No. director, 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) PLACE OF DEATH a. COUNTY b. COUNTY MARYLAND COMICIC 950 b. CITY OR TOWN (If outside corporate limits, write c LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) RURAL (and give nearest town) d NAME OF HOSPITAL (If not in hospital, give street address) e IS RESIDENCE d. STREET ADDRESS OR INSTITUTION ON A FARM? þ YES NO PY Middle 4. DATE NAME OF Last Month Year filled DECEASED 195 2 DEATH (Type or print) non 9. AGE (In years last brithday) IF UNDER 1 YEAR IF UNDER 24 HRS S SEX 6 COLOR OR RACE 7. MARRIED KI NEVER MARRIED Months Davs Hours DIVORCED [WIDOWED | 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) actory puo carban 14 MOTHER'S MAIDEN NAME 13' FATHER'S NAME E physici remove IS. WAS DECEASED EVER IN U. S. ARMED/FORCES? 16 SOCIAL SECURITY NO. INFORMANT offending edse INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).] ONSET AND DEATH ā PART I. DEATH WAS CAUSED BY: 2010 IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gned gove rise to immediate DUE TO couse (a), slating the underlying couse last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO T 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 1B.) 20g ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) 20c. TIME OF INJURY Day, Year 20d. INJURY OCCURRED (State) Month. (County) foctory, street, office bldg., etc.) Hour a.m. While Not while of work of work p. m Mot I lost sow the deceased that I attended the deceased from alive on and that deoth occurred at M. from the couses and on the date stated above. ADDRESS (Street city or lown, stole) ACTUAL prior SIGNATURE shauld may be ren.
TO FUNERAL F Salisbury. PHYSICIAN'S Mitchell R.C. NAME [Type] 220. BURIAL, CREMATION, 226. DATE THEREOF 22d. LOCATION (City, lown, or county) 22c. NAME OF CEMETERY OR CREMATORY (State) REMOVA, (Specify) Mt. Calavary Exmore Remo-Burial 24b REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 240, REC'D BY REGISTRAR arthur & Knows VS A1S (4) lomal DATE 1SM 9/SB

death

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



TO FUNERAL DIRECT. After this certificate has been signed by the attending physicion and completely filled in by the page 3 should be detached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shan the registror prior to burial, cremotian, or removal, and in any event within 72 haurs after death.

IDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs aff

TO HOSPITAL OR

VS A15 (4) 15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 4955

CERTIFICATE OF DEATH

04950

Reg. Dist. No

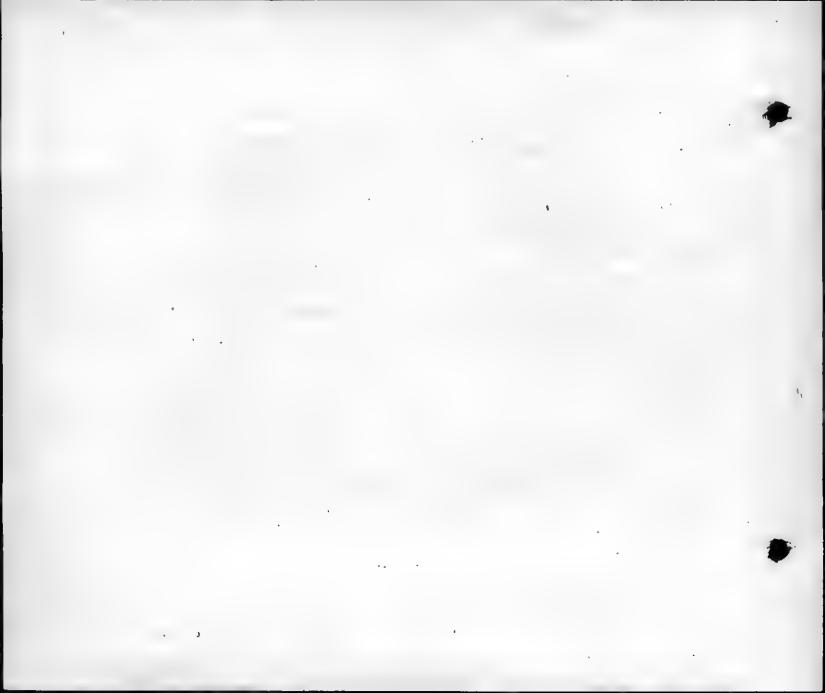
- 1			
	1. PLACE OF DEATH O. COUNTY WICOMICO MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before o. STATE b. COUNTY OR CIE	
	b CITY OR TOWN (If outside corporate limits, write RURAL and give rearest town)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give ne	orest town)
	DNAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FENINS WHA GENETAL HOSPITAL	d STREET ADDRESS CHILADELPHIA AVE	e. IS RESIDENCE ON A FARM? YES NO A
	3. NAME OF DECEASED (Type or print) VILLIAM FRANK	TIRE OF DEATH APRIL 2"	Y Yeor 19 5
		B. DATE OF BIRTH 9. AGE (In years IFUNDER I YEAR lost birthday) Months Days yrs.	IF UNDER 24 HRS. Hours Min.
1	100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRIBLE OF WORKING LIFE, EVEN IF retired) RETIREDEN FINEER RAIL ROAD	STRY 11. BIRTHPLACE (State or foreign country) 12 CITIZENO	S. A. D.
1	13. FATHER'S NAME	ELIZAS STH. WILLIAMS	
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. If (Vet., no. or unknown) (If yes, page yor or doles of service)	NFORMANT Address PAS VIF TXRE CCEAN CITY	Mp.
	1B. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)		ERVAL BETWEEN SET AND DEATH
	Conditions, if ony, which (b)		
	gove rise to immediate couse (a), stating the under lying couse last. DUE TO (c)		
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT		PERFORMED? YES NO
	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	D. (Enter nature of injury in Part I or Part II of Item 18)	
		ACE OF JNJURY (Home, form, 20f. (City or town) (County) ctary, street, office bldg., etc.)	(State)
	21. I certify that I attended the deceased from 4-14- alive an 4-3-1, 12-1, and that death	accurred at DEM, from the causes and on the date	
	ACTUAL SIGNATURE (, , , , , ,)	ADDRESS (Street, city or town, state) M.D.	DATE SIGNED
	PHYSICIAN'S NAME (Type)		
	220 BURIAL CREMATION, 226 DATE THEREOF 220. NAME OF CEMETERY OF CE		(Stote)
	23' FUNERAL DIRECTOR'S SIGNATURE Bubye Berlin	DATE MAY 1 150 246. REGISTRAR'S SIGNATU	IRE



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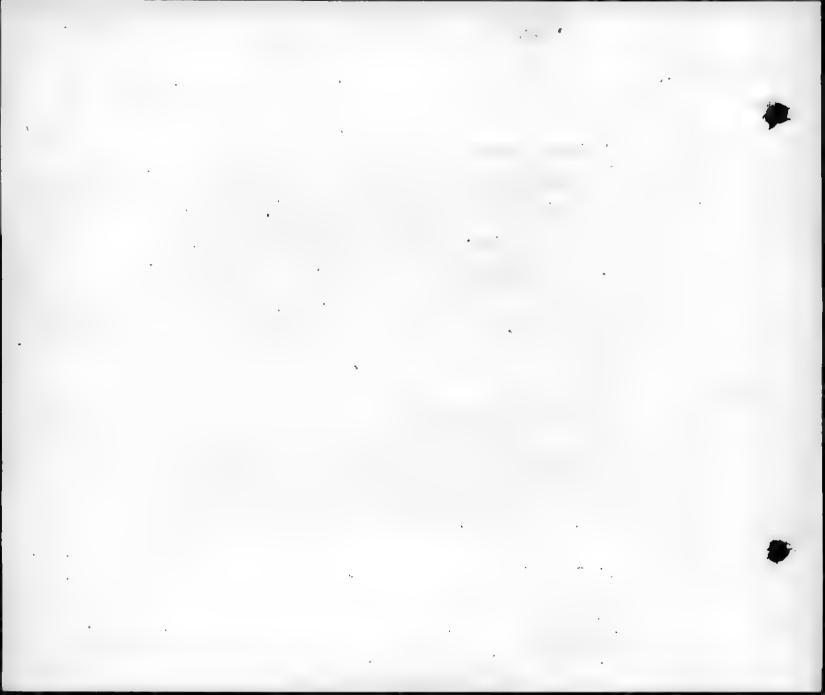
MARYLAND STAT	TE DEPARTMENT OF HEALTH	BALTIMORE, 18	
4956 nformation	taken from birth Cert. CERTIFICATE OF DEATH	et	04951
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1. PLACE OF DEATH o. COUNTY	USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE COUNTY								
WICOMICO MARYLAND	Maryland b. COUNTY Worcester								
B. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town)	c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest lown)								
SALISBURY	Berlin 2.3x-2								
d, NAME OF HOSPITAL (If not in hospital, give street address)	d. STREET ADDRESS e. IS RESIDENCE								
PENINSULA GENERAL HUSPITAL	P. O. Box 202								
3. NAME OF First Middle									
DECEASED (Type or print)	WAPLES DEATH APRIL 17 1959								
5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED	8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS								
MALE COLORED WIDOWED DIVORCED	APRIL 15 1959 last birthday) Months Pays Hours Min.								
10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUS	TRY 11 SIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY?								
during most of working life, even if retired)									
13. FATHER'S NAME Harrison	14. MOTHER'S MAIDEN NAME								
Zi naiiison	Lois Lorraine Worthington								
	NFORMANT Address								
(Yes, no, or unknown) [If yes, give war or dates of service]	arl Waples Berlin Md.								
18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]	ATL Waples Berlin Md. INTERVAL BETWEEN								
PART I, DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a)	17 DIVINWI GIUGINS)								
776 X DUE TO									
Conditions, if any, which) gave rise to immediate (b)									
couse (a), stating the under-									
lying couse last.) (c)									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?								
L C	YES NO								
OR CONTRIBUTING CAUSE OF DEATH	D. (Enter noture of injury in Part I or Port II of item 18.)								
20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PL	ACE OF INJURY (Home, form, 20f. (City or town) (County) (State)								
20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED Hour a.m. p. m. 19 ol work of work	tory, street, office bldg., etc.)								
21. I certify, that I attended the deceased from A V 1 1	5 , 1959, to April 17, 1957, that I last saw the deceased								
	occurred at 14: 27/2.M, fram the causes and an the date stated abave.								
	ADDRESS (Street, city or lown, state) DATE SIGNED								
ACTUAL SIGNATURE	w.b.								
PHYSICIAN'S NAME (Type)									
220. BURIAL, CREMATION, 22b. DATE THEREOF 22c NAME OF CEMETERY O	R CREMATORY 22d. LOCATION (City, town, ar county) (State)								
burial 4/17/59 evergreen	Berlin Ma								
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE								
White of Struck Sales and mil	DATEAPR 2 2 '59 Cathon & House								
	THE PARTY OF THE P								



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Rea. Dist. No 2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) . IS RESIDENCE ON A FARM? YES 📉 NO 🗌 Year 19 cf IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours 12. CITIZEN OF WHAT COUNTRY? HUNDERSON INTERVAL BETWEEN ONSET AND DEATH PERFORMED? YES T NO P (Stote) (County) That I last saw the deceased from the couses and on the date stated above. 22d. LOCATION (City, town, or county) (Stote)



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 4958 CERTIFICATE OF DEATH Rea. Dist. No 14 PLACE OF PRATH 2. USUAL RESIDENCE (Where deceased fixed. If institution: Residence before admission) o. COUNT **b** COUNTY MARYLAND NO b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) RURAL and give nearest town) AISTITUTION, not in-hospital, give street address d. STREET ADDRESS 4. DATE DECEASED DEATH (Type or print) 9. AGE (In years lost birthday) S. SEX MARRIED NEVER MARRIED IF UNDER 1 YEAR IF UNDER 24 HR Months DIVORCED IT WIDOWED 🖫 10a USLAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country) during most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY? SELF EMPLOVED BALILY puo 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME physician SURGE 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANI 3 GALI offending CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).] 급 PART I. DEATH WAS CAUSED 8Y: IMMEDIATE CAUSE (a) DAMEUWICHI **DUE TO** (Guss Conditions, if any, which gned gave rise to immediate DUE TO couse (a), stating the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY 70-13195 EKOSIZ 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.) MEDICAL 20c. TIME OF INJURY Month. Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) foctory, street, office bldg., etc.) a. m. While Not while of work of work 21. I certify that I attended the deceased from March 20 195 (that I last saw the deceased alive an and that death occurred at 10-12-M, from the causes and on the date stated above ADDRESS (Street, city or town, state) ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)

22c. NAME OF CEMETERY OR CREMATORY

ADDRESS

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VS A15 (4) 15M 9/58

270. BURIAL, CREMATION, 22b. DATE THEREOF

REMOVAL (Specify)

23. FUNERAL DIRECTOR'S SIGNATURE

24n, REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

22d LOCATION (City, town, or county)

04953

U. S 17

INTERVAL BETWEEN ONSET AND DEATH

2 (Yese

PERFORMED? YES NO

(Stote)

(County)

(Stote)

IS RESIDENCE YES NOT

Year

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VS A15 (4) 15M 9/58

MARYLAND	STATE	DEPARTMENT	OF	HEALTH-BALTIMORE,	l
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CERTIFICATE OF DEATH

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4202 Reg. Dist. No. PLACE OF DEATH .. 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. COUNTY b. COUNTY MARYLAND DOMERSET CITY OR, TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) d. NAME OF HOSPITAL-HF-ylat in haspital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? OR NSTITUTION YES NO L NAME OF Middle 4. DATE Year DECEASED DEATH (Type or print) 195 5. SEX 6. COLOR OF RACE 7. MARRIED F NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS lost birthdoy) Months Days WIDOWED | DIVORCED [7] yrs 10a. USJAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or fareign country) during most of working life, even if retired) 12 CITIZEN OF WHAT COUNTRY? FOOD 13. FATHER'S NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT Address 18. CAUSE OF DEATH [Enter only one cause get line for (9), (b), and (c).] INTERVAL BETWEEN PART I, DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gove rise to immediate **DUE TO** cause (a), stating the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMEDA YES NO T 200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Part 11 of item 18.) OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) foctory, street, office bidg., etc.) Hour o.m. Not white While 19 of work of work p. m. 21. I certify that I bitended the deceased from that I lost sow the deceased alive on and that death occurred at JaM, from the causes and on the date stated above. DATE SIGNED ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) 220. BURIAL, CREMATION 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATOR 22d. LOCATION (City, (State) REMOVAL (Specify JOHN FUNERAL DIRECTOR'S SIGNATURE 24h REGISTRAR'S, SIGNATURE



VS A15 (4) 15M 10/57 91

	MARYLAND S	STATE DEPARTMENT OF HEALTH—BALTIMO	ORE, 18
	4960	CERTIFICATE OF DEATH	R
1. PLACE OF DEATH		2 LISHAL DESIDENCE (Where Jacoured Good	It made at a

(14955 Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Wil	comico		MAR	YLAND	2 USUAL o. STAT	RESIDENCE (Whe		d lived. If instituti b. COUNTY		before c	
b. CITY OR TOWN	If outside corporate fimi	ts, write	c. LENGTH OF STAY	IN 1b	c. CITY			orate limits, write f			
RURAL and give n	earest town) Lisbury		3 mos.	3 Dal	10.	Salis					,
d. NAME OF HOSPI	TAL (If not in hospital, g	ive street	address)	, 20	d. STRE	ET ADDRESS	J 442 J			e. I	S RESIDENCE
OR INSTITUTION Dec	er's Head S	tate	Hospital		/	308 F	fammor	nd Street			ON A FARM?
3. NAME OF	Fic		Middle		<u> </u>	Last	4. DATE	Mor		Day	Yeor
(Type or print)	Carri	e	M.	•	,	White	OF DEATH			11	19 59
5. SEX	6. COLOR OR RACE	7. MARI	RIED NEVER MARRI	IED 🚺	B. DATE OF	BIRTH		9. AGE (In years		YEAR IF	UNDER 24 HRS.
Female	White	WIDOW	ED DIVORCE	ED 🔲	April	13, 188	35	lost birthday)	Months D	ays H	ours Min,
10a. USUAL OCCUPATION during most of wor	ON (Give kind of work	done 10b.	KIND OF BUSINESS O	OR INDU				ountry)	12. CITIZ	EN OF V	HAT COUNTRY
hone	king lite, even it retired	'	None			Maryl	land		U	. S.	Α.
13. FATHER'S NAME					14. MOTH	ER'S MAIDEN N		arah Wh			
]	Deceased (G	ordo	on White)					eceased	200 21	- IL 10 C	/ A. I.
15. WAS DECEASED EVE	R IN U. S. ARMED FOR	CES? 16			NFORMANT	Mrs. Ma	rion	Hasti r	os Ni	ece)	Sal. Md
Unk.	(ii yes, give war or dates ar s	ervice)	Unk.		H	ospital	Recor	ds Sa	lisbur	y. M	aryland
	ATH [Enter only one co	use per li	ne for (o), (b), and (c)	1		2000			-	INTERV	AL BETWEEN
PART 1. DEA	TH WAS CAUSED BY:	1	Generaliz	ed Ca	arcino	ma				ONSET	AND DEATH
1: 1	DUE TO										
Conditions, if ony, which) (b) Ca of Colon									?		
	gove rise to immediate couse (a), stating the under-										
lying couse lost.	(c										
PART II. OTI	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) 19. WAS AUTOPSY										
PANT II. OTI		Seco	ndary Anem	ia							ERFORMEDA
	AS UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)		CRIBE HOW INJURY O), (Enter natu	re of injury in P	art I or Par	t II of ilem 18)			0
20c. TIME OF INJUR	Y Month, Doy, Yes	≭ 20d. II White	VJURY OCCURRED Not while	20e. PL/	ACE OF INJU	RY (Home, form, office bldp., etc.)	20f. (City	or town)	(Co	uniy)	(Stole)
p. m.	19	at wor									
21. I certify th	at Lattended the	deceas	ed from $1/7/$	/59	, 19	, ta	/11/9	2 19	that I la	st saw	the decease
alive on	4/11/59	, 12	, and that	death	accurred	at 1:58A	M, from	n the causes o	and an the	date	stated above
	1. 17 -		,					treet, city or town,			DATE SIGNE
ACTUAL SIGNATURE	Ar, Vifue	ru	lan.		W.D	Salis	bury.	Marylan	d		4/11/59
PHYSICIAN'S NAME (Type)	V. Juern	an, I	1.D.								
220. BURIAL, CREMATIO REMOVAL (Specify) BURIAL	Apr.13.		22c. NAME OF CEM		emete			ion (City, town, o			(Stote)
23. FUNERAL DIRECTOR			ADDRESS			24a. 056			TRAR'S AIG		
YAWOLLOH	& COMPANY	S	ALISBURY	MAR	YLAND	DATE	155	g COV	mul 2 71	raile,	



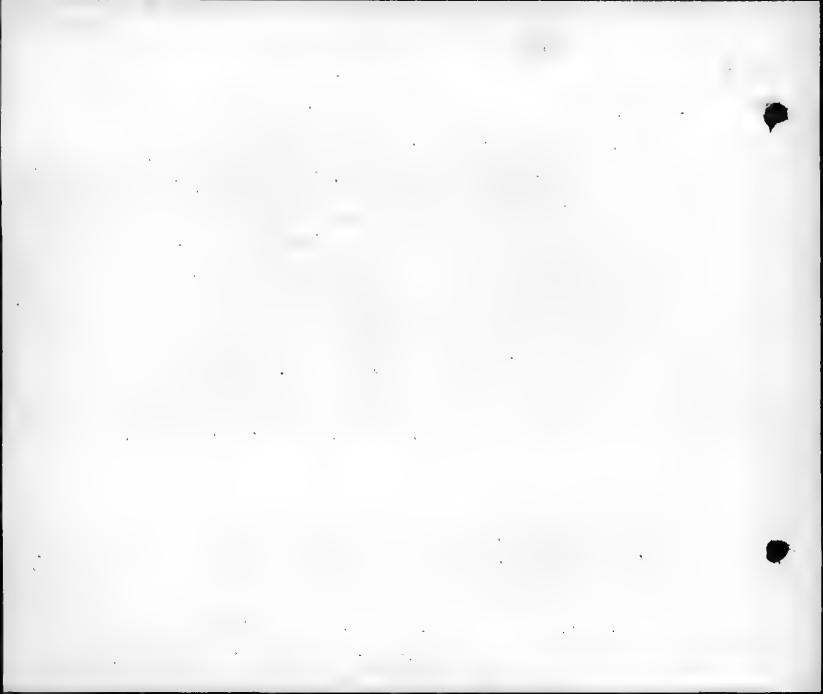
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 **CERTIFICATE OF DEATH** 4961 eral directar, be filed with death. Page 4

Reg. Dist. No.

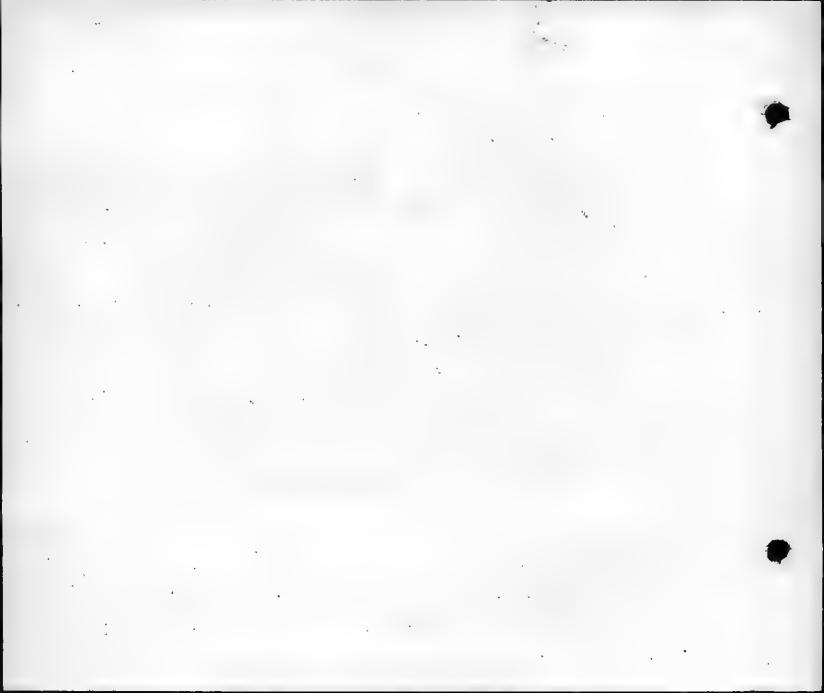
1. PLACE OF DEATH o CQUNIY		L RESIDENCE (Where deceased live		before admission)
L'ICOMICO	MARYLAND 0. ST	ARVLAND.	6. COUNTY	C ESTIER
b. City OR TOWN (If outside corporate limits, write C LENGT) (RUR#L and give nearest town)	H OF STAY IN 16 c. CIT	Y OR TOWN (If outside corporate I	limits, write RURAL and giv	e negrest town)
11161 2	VECIL	BERLIN	X	E4
d. NAME OF HOSPIFAL (If not in hospital, give street address) OR INSTITUTION	d. ST	REET ADDRESS		e. IS RESIDENCE ON A FARM?
ENINSULA CENERAL HOSP	TA	OCEAN CITY	Huray	YES NO D
3. NAME OF DECEASED (Type or print) ETHEL RELL	Middle \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Last 4. DATE OF DEATH	ACCIA C	Day Year
S. SEX 6. COLOR OR RACE 7. MARRIED NEV				YEAR IF UNDER 24 HRS
FEMALE WHITE WIDOWED	DIVORCED A PA	11 3.1911 2	ost Birthdoy) Months Di	ays Hours Min
10a USJA, OCCUPATION (Give kind of work done 10b KIND OF 8 during most of working life, even if retired)	USINESS OR INDUSTRY 11, 8	RTHPLACE (State or foreign country	y) 12 CITIZE	N OF WHAT COUNTRY?
HOUSEVULEE OWN	HOME	NEWARK 1	MOI	USA
13. FATHER'S NAME	14. MO	HER'S MAIDEN NAME		
IAMES H. WEBB.	Ro	SA BELLE R	CICHARI	05
15 WAS DECEASED EVER IN U. 5 ARMED FORCES? 16. SOCIAL SEC (Yes, no. or unbigowin) [(If yes, give wor dyndolily of service)	CURITY NO. INFORMAN		Address	2 12/1
No No	o WIS	DTHO J. WILL	LIAMS A	JERLIN I'L
18 CAUSE OF DEATH [Enter only one couse-per line for (o), (I	b), and (c).]	/		INTERVAL BETWEEN ONSET AND DEATH
PART I, DEATH WAS CAUSED BY IMMEDIATE CAUSE TO	- (// = 1.	in to he		CINSEL AND DEATH
33/X DUE TO 1	2 2 1	6 11		/ //
Conditions, if ony, which)	n (G +	care : Cere	val.	17
gove rise to immediate Couse (a), stating the under-				
lying cause lost				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTI	NG TO DEATH BUT NOT RELA	ED TO THE TERMINAL DISEASE CO	NDITION GIVEN IN PART 1	(o) 19 WAS AUTOPSY
3 / i'vere therine	(estrice I	o & andore	attre Tan	YES NO
OR CONTRIBUTING CAUSE OF DEATH	INJURY OCCURRED. (Enter in	olure of injury in Port I or Port II of	f (fem 18.)	
	100 0100 05 11			
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCC	faulus den	JURY (Home, form, 20f. (City or to , office bldg , etc.)	own) (Cou	unty) (Stote)
≥ p. m. 19 at work □ at work		1.,		
21. I certify that I attended the deceased fram.	5-12 mill. 1!	57, tapa . sol 1	, 19.2.5/that I last	saw the deceased
alive an 1/1 (2/2/2/1/1), 19, 12, 12, 12, 12, 12, 12, 12, 12, 12, 12	and that death occurre		causes and an the o	date stated above.
ACTUAL 7 0 1		ADDRESS (Street,	city or town, state)	DATE SIGNED
SIGNATURE	MD	the of my fi	2 7 1/2	(1) /55
PHYSICIAN'S NAME (Type)				/ /
DEMOVAL (Specify)	AE OF CEMETERY OR CREMAT	DRY 22d. LOCATION	(City, lown, or county)	(Stote)
BURIAL 4 11 59 E	ver fre	N BER	ZLIN	/V/D
23. FUNERAL DIRECTOR'S SIGNATURE ADDR	ress o · ha	24a REC'D BY REGISTRAR	24b. REGISTRAR'S SIGN	
Home H. James	man in	DATAPR 1 4 '59	Curina & K	ince

may be retained. After this certificate has been signed by the attending physician and completely filled in by transcription and completely filled in by transcription and completely filled in by transcription page 3 shauld be detached far use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 shauld be the registrar priar to burial, cremation, ar remaval, and in any event within 72 haurs after death. FIDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after TO HOSPITAL OR PUT

VS A15 (4) 15M 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



may be retained by may be retained by 10/21 (4) 10/21 (4

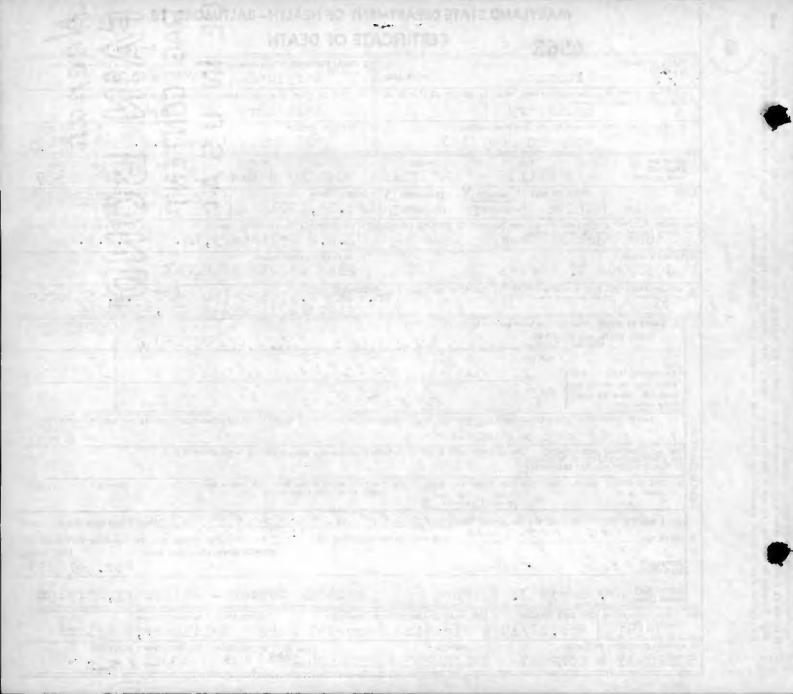
083

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CERTIFICATE OF DEATH 4963

Reg. Dist. No.

1. PLACE OF DEATH a: COUNTY	Wkcomic	0	MAR	YLAND	2. USUAL RESIDEN o. STATE Maj	ce (Where d	deceased	lived. If instituti b. COUNTY	on: Resider	mic before	e odmissi	on)
b. CITY OR TOWN (If RURAL and give nea	outside corporate limi		LENGTH OF STAY	IN 1b	c. CITY OR TOW	VN (If outside			ural ond	give neo	rest town)
d. NAME OF HOSPITA OR INSTITUTION	Pen Gen				d. STREET ADDR		dy I	Lane (H			ON A	FARM?
3. NAME OF DECEASED (Type or print)	NEL.		CATHE:		E WIMBRO		DATE OF DEATH	APRII		9th		959
5. SEX Female	White	WIDOWED [_	0 0	B. DATE OF BIRTH Dec . 14, 1			AGE (In years last birthday) yrs.	IF UNDER	1 YEAR Days	Hours	R 24 HRS. Min.
during most of works	N (Give kind of work ing life, even if refined OPK at H	one 10b. KIND	None	OR INDUS	R.D.#					IS.		COUNTRY
JOSEPHU	S E. ADK	INS			MARY C			BROWN				
15. WAS DECEASED EVER	IN U. S. ARMED FOR f yes, give wor or dotes of s	CES? 16. SOCI	IAL SECURITY NO	Mr	John M. ane (Box#	Wimbı 23)	row(Husban	d)R. Mar	D.#	5 Go	rdy
PART I. DEAT 5 8 7. 0 Conditions, if an gave rise to im cause (a), stating the lying cause last.	mediate (WE DITIONS CONT	the .	tio Le pa	gic of econology to the a	J. C.	CCE	A:I	EN IN PAR	J	PERFOR	UTOPSY MED?
Pagt II. OTHE		20b. DESCRIBE	HOW INJURY O		D. (Enter nature of inj						YES 🔀	№ □
20c. TIME OF INJURY Heur a.m. p. m.	Manih, Day, Yeo	While	Y OCCURRED Not while at work	70e. PLA	CE OF INJURY (Hom lory, street, office bld	e, farm, 20 g., etc.)	Of. (City o	r lawn)	(0	County)		(Stale)
ACTUAL SIGNATURE PHYSICIAN'S Dr NAME (Type)	. David	3 Cu	and that		accurred at 1	ADDR	RESS (Stree	the causes and city or fown, Sali	nd an ti	pr.	DA:	d above te signed /59
220. BURIAL, CREMATION REMOVAL (Specify) BUTIAL	Apr. 12,		Wicomic		e crematory emorial			alisbu	- 1	ary	(Stote	
HOLLOWAY		Z SA	ADDRESS LISBUR	Y MA	RYLAND DA	APR 1	REGISTRA 3 '59	R 24b. REGIS	TRAR'S SIC			



tral director, be filed with ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after diath. Page 4

D FUNERAL DIRECT After this certificate has been signed by the attending physician and campletely filled in by the page 3 should be verached for use as the burial-transit permit. Then please remove corban papers. Peace 1 and 2 sho the registror prior to burial, crematian, ar removal, and in any event within 72 hours after death.

e haspital or attending physician.

TO FUNERAL DIRECTORS 2 should be 3

VS A15 (4) 15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4964

CERTIFICATE OF DEATH

	U	4	J	C
Reg.	Dis	t. P	ło.	

1. PLACE OF DEATH					2. USUAL RESIDENCE (Who	ere deceased	lived. If instituti	on: Residence	e before	admiss	ion)
o. COUNTY	Wicomico	6. STATE Maryland b. COUNTY Baltimore City									
b. CITY OR TOWN RURAL and give	(If outside corporate limit	s, write	c. LENGTH OF STAY	IN 1b	c. CITY OR TOWN (IF or	utside corpor	ote limits, write F	URAL ond g	ive neare	est fowr	1)
	Salisbury		227 days	3	Baltin	more		3 V 8	0/-	4	V
d. NAME OF HOS OR INSTITUTION	PITAL (If not in hospital, gi	ive street	oddress)		d. STREET ADDRESS				e.		IDENCE
	r's Head Sta	te H	ospital		1029 B	altimo	re Stree	et	-		FARM?
3. NAME OF DECEASED	Fire	it	Middle		Lost	4. DATE	Mor	ıih	Day		Year
(Type or print)	Andr	ew			Wisniewski	DEATH	Apr	il	2	1	1959
5. SEX	6. COLOR OR RACE	7. MARI	RIED NEVER MARRIE	D.K.	B. DATE OF BIRTH		AGE (In years	IF UNDER	YEAR IF	UNDE	R 24 HRS.
Male	White	WIDOW	ED DIVORCE		November 22,	1908	lost birthday) 50 yrs.	Months	Days I	Hours	Min.
10a. USUAL OCCUPA	TION (Give kind of work d	one 10b.	KIND OF BUSINESS O	R INDU	STRY 11. BIRTHPLACE (Stole of		untry)	12. CITI	ZEN OF	WHAT	COUNTRY
dorring mast at w	arking life, even if retired)				Baltimo	ore. M	arvland		USA	A	
13. FATHER'S NAME					14. MOTHER'S MAIDEN N		0				
F	rank Wisniew	ski			Cywins						
15. WAS DECEASED E	VER IN U. S. ARMED FOR		SOCIAL SECURITY NO	17, #	NFORMANT		Add	ress	-		
(Yex no. or unknown)	(If yes, give wor or dofes of se	rvice)			Hospital Reco	ords !			rvlar	nd	
4 1 4 5 7	EATH [Enter only one cou		foo to) (b)		HOODE GOT HOOG	,, ,,	OCLIDOCL	J 9 1244.	1		
	EATH WAS CALISED BY										DEATH
1110 V	MMEDIATE CAUSE (0)	Sq.	cell carc	inom	a of pharaynx				13	mo	nths
1400	DUE TO										
Conditions, if											
gove rise to couse (o), statin											
lying couse las											
PART II. C	THER SIGNIFICANT CON	OITIONS (CONTRIBUTING TO DEA	TH BUT	NOT RELATED TO THE TERMIN	HAL DISEASE	CONDITION GIV	EN IN PART	1(0) 19	WAS	AUTOPSY
\$											NO-E
PART II. CO	WAS UNDERLYING A	20b. DES	CRIBE HOW INJURY OF	CCURREC	D. (Enter nature of injury in Po	ort I or Port	II of item 18.)				
U (IF EITHER, NOTI	YG CAUSE OF DEATH EXAMINER CAUSE OF DEATH										
T 20c. TIME OF INJ	URY Month, Day, Yea	r 20d II	NJURY OCCURRED	20e. PL/	ACE OF INJURY (Home, farm,	20f (City)	ar town)	10	ounty)		(Stote)
20c. TIME OF INJ	16	While	Not while	fac	tary, street, office bldg., etc.)	1 (0.1)	31 10411,	10	Bonny;		(Stole)
		of wor		/	20 .	1	20				
21. I certify	that I attended the	deceas	ed from Augus	t 10	8 . 19 58 to AT	oril 2	, 1 <u>99</u>	that I le	ast saw	r the	deceased
alive on	April 2	_, 19	59, and that	death	accurred at 11:301	M, from	the causes o	and an th	e date	state	d abave.
			•		A	DORESS (Stre	et, city or town,	state)			TE SIGNED
ACTUAL SIGNATURE	a. Kes	مؤله صلهما	to be		M.o. Deer's He	ead Sta	ate Hosp	ital		4/	/3/59
PHYSICIAN'S	G. Kosmah	1 75 6	D								
NAME (Type)	de Robindii.	-J 9 1	1. D.		Salisbury	, Mar	yLand				
	ION. 726 DATE THEREO	:	22c. NAME OF CEME	TERY OF	R CREMATORY	22d_LOCATI	ON (City, town,	or county)		(Stole	21
REMOVAL (Specif	Caril	2.5	7 Nt O	ta	nielan	130	Itima		had	/	"
23. FUNERAL DIRECTO	OR'S SIGNATURE,	/	ADDRESS 10	21	240. RFC'D	BY REGISTR		STRAR'S SIG	NATURE	4	
I nod	21) (/2 1	4 04	1 2 h 78	0 1	Tana Gas DATE A			Irilan 2		u.A.	

ST SET METALEMENT OF THE MEAN TO THE METALET STATE STALL TO THE The state of the s Commence of the second second The second of the second PARC BEAT PARCELLE LA LICE